Avalon
HOLISTIC THERAPIES

Health Benefits Verification

Insurance Information:

Client's Name _____ DOB _____

Insured's Name _____ Insured's DOB _____

Name of Insurance _____ Phone Number _____

Employer's Name _____ Group ID# _____

ID # _____ Allowable Benefits _____

Co-Pay/Co-Insurance _____ Need Prescription? □ Yes □ No

We will happily bill your insurance for your visit; however, it is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums. Please follow steps 1-7 when calling to find out benefits and eligibility.

First, call the number on your insurance card listed for customer service, benefits and eligibility, or subscriber services and ask the representative the following questions:

1. Name of Representative_____ Date/Time of call_____
2. Do I need a referral from my primary care physician (PCP) for alternative services?
   □ Yes □ No
3. Is the practitioner I want to see (Ann-Marie Hall-Pond) in-network or a preferred provider?
   □ Yes □ No
4. What are my benefits for the following services?

   ***Be sure to find out which benefits apply to the practitioner you are seeing; there will be different benefits depending on whether the practitioner is In or Out-of-Network with your insurance company and whether your plan includes Out-of-Network benefits. ***

- Manual Therapy/Massage (Code 97140)
  % Covered _____ Co-Pay/Co-Insurance _____ Year Max _____ Pre-Auth? □ Yes □ No
- Chiropractic
  % Covered _____ Co-Pay/Co-Insurance _____ Year Max _____ Pre-Auth? □ Yes □ No
- Naturopathic
  % Covered _____ Co-Pay/Co-Insurance _____ Year Max _____ Pre-Auth? □ Yes □ No
- Acupuncture
  % Covered _____ Co-Pay/Co-Insurance _____ Year Max _____ Pre-Auth? □ Yes □ No
- Physical Therapy
  % Covered _____ Co-Pay/Co-Insurance _____ Year Max _____ Pre-Auth? □ Yes □ No

5. What is my deductible for the year and what is the status?

Deductible $_____ Amount of Deductible met $_____ As of (Date) _____

Please bring this form with you to your appointment. If you have trouble, don't hesitate to call. We are happy to help!

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Insurance Release & Agreement

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I, _____, (the client) authorize Avalon Holistic Therapies (the provider) to furnish my records to the insurance company or an attorney for the purpose of obtaining payment on my account for service provided to me. In addition, I hereby authorize payment directly to Avalon Holistic Therapies for all Massage Therapy benefits otherwise payable to the undersigned or the client.

I understand that I am responsible for any additional charges not covered by my insurance including co-payments, deductibles and late cancellation fees. I will pay within 30 days of billing or a **late charge of $5 per month will apply**.

I, _____, agree to pay in full all amounts due to Avalon Holistic Therapies for services rendered if, for any reason, the insurance company has not submitted payment within six months from the initial billing date. **If this creates a financial hardship, I will contact Avalon Holistic Therapies within the first 30-day billing window to discuss payment options.**

For Motor Vehicle Accident Claims - If the claim goes to settlement before six months from the billing date and Avalon Holistic Therapies has not been paid in full for services rendered, I, the client, agree to have the unpaid balance paid to Avalon Holistic Therapies by my attorney from the settlement funds before I receive payment.

If the insurance company submits payment to Avalon Holistic Therapies after I, the client, have paid; Avalon Holistic Therapies will reimburse the client within two weeks of receiving the check from the insurance company.

_____ _____
(Client Signature) (Date)

_____ _____
(Representative of Avalon Holistic Therapies) (Date)

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