AMY YAPLE, L.P.N./ L.M.T.

OFFICE POLICIES- THERAPEUTIC MASSAGE

Practitioner/ Clinic Name: _____

Contact Information: _____

CLIENT INFORMATION:

Client Name: _____ Date: _____ Date of Birth: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

CANCELLATION:
A 24-hour notice is required for cancellation of an appointment. We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/ late cancellation fees.

TARDINESS:
Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals.

SICKNESS:
Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you aware of an infectious or contagious condition within a 24 hour period.

IF THIS OFFICE IS PROVIDING BILLING SERVICES, PLEASE BE ADVISED IF OUR BILLING PROCEDURES.

FINANCIAL RESPONSIBILITY:
Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event, that the insurance company denies payment or makes a partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

ASSIGNMENT OF BENEFITS:
Your signature below authorizes and directs payment of medical benefits to the massage/ bodywork practitioner for services provided by this office.

RELEASE OF MEDICAL RECORDS:
Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: the attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

SIGNATURE: _____ **DATE:** _____