Eastside Massage Clinic **Phone 425.455.2320** **Fax 425.455.2473**

Name: _____Date of Birth: _____Sex: M___ F___

Address_____Last 4 Digits of SSN#_____

City/State_____Zip_____Marital Status_____

Home Phone: _____Cell Phone_____ Work Phone_____

E-Mail address _____ Do we have permission to text/email? Y_____ N_____

Employer: _____Type of Work_____

Primary HealthCare Provider_____ PCP Phone Number_____

Do we have permission to contact your Primary HealthCare Provider? Y_____ N_____

Who should we thank for referring you to our clinic? _____

Insurance

Please provide your insurance card or the following:

Insurance Carrier's Name_____
Subscriber Name_____ Subscriber DOB_____
Policy or Claim Number_____
Claim Manager_____Phone_____
Address to Mail Claims to_____

It is your responsibility to know your benefit coverage including deductibles, co-pays, co-insurance, and limitations and to fulfill the requirements of your policy. We are **happy to assist you**; however, **we do not assume responsibility** for denied claims.

Prescription

A current **prescription from your doctor is required in order for an insurance claim to be submitted** on your behalf. As you near the limit of your prescription, please contact your doctor's office regarding a prescription for additional treatment prior to your next massage appointment. If you have any questions please feel free to ask our billing staff. We are **happy to assist you** in keeping track that your visits do not exceed the frequency and duration of treatment as prescribed by your doctor. However, **we do not assume responsibility** for appointments scheduled that exceed your prescription. If we are unable to submit an insurance claim or if insurance denies/recalls payment due to lack of a valid prescription you will be responsible for unpaid balances for each applicable date of service.

Office Protocols

Co-pays and co-insurances are due at time of appointment check-in.
Missed appointments and cancellations with less than 24 hours notice will be charged $75.00.
Patients are responsible for payment of charges not covered by insurance within 30 days from invoice date
A $15.00 rebilling fee and/or interest will be charged each month until balance due is paid.
Returned checks will be charged $40.00.
Patients are responsible for any and all fees associated with collections including liens.

I understand and agree to the above and have received a copy of clinic policies:

Patient/Guardian Signature_____Date_____

02/14