Medical Insurance Information / Credit Card Pre-Authorization / Clinic Policies

Your Medical Massage benefits are through _____

Your annual deductible is _____

Your co-pay amount is _____ per session

Your out-of-pocket co-insurance amount is _____

Credit Card Pre-Authorization: I authorize my provider and SOMA THERAPEUTICS, PLLC / d.b.a (ALIGN360) to keep my signature on file and to charge the credit card selected below for any out-of-pocket charges I am responsible for including late cancellation and no show appointment fees:

Check One: HSA ____ Visa ___ American Express ____ Master Card ____ Discover Card ____

____I ALREADY HAVE MY CARD ON FILE (_____) LAST 4 DIGITS

Name: _____

Cardholder Name: _____

Cardholder Billing Address: _____

City: _____State: _____ Zip:_____

Card Number:_____ Exp. Date_____CVV Code_____

Cardholder Signature _____Date:_____

For PIP (Personal Injury Protection) claim, please provide information below (Insurance company, claim number, claim adjusters name, telephone number, fax number & mailing address)

_____

_____

_____

_____

_____

(turn over to complete)

Cancellation/No Show Policy:

_____ **(Initial)** Your appointment time has been set aside specifically for you. If you must cancel or reschedule an appointment, please give us ***48 hours notice. Any cancellation or reschedule made within 48 hours of your appointment will be charged the full amount for the service. PLEASE NOTE: medical insurance will not be billed and this will be an out-of-pocket expense*** We cannot bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fee.

Payment:

Fee for Medical Massage is $165.00 per 50-minute hands-on session.

_____**(Initial) For those out-of-network or if you have an unmet deductible with your in-network benefits, a Credit Card Pre-Authorization must be kept on file (see back side).** Co-pays must be paid at time of service by check, cash, credit card, or Healthcare Spending Account (HSA) card payments. A Credit Card or HSA payment will be be made at time of service. For your convenience, we require you to sign a ***Credit Card Pre-Authorization Form*** which will allow co-pays to be charged at time of service, or coinsurance to be charged once your insurance is processed.

_____**(Initial)** There will be a $35.00 fee for any returned checks. If a check has been returned, we will require further payments to be made by cash or cashier's check.

Financial Responsibility:

_____**(Initial)** 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 partial payment, you are responsible for the balance, deductibles, co-pays & coinsurance. This includes denials for pre-authorization & maxed out benefits. It is your responsibility to track the number of services you have available to you within a calendar/benefit year. Your signature below confirms your financial responsibility for all services regardless of insurance payment. ***Invoices over 60 days past due, will be forwarded to collections and could negatively impact your credit score.***

Assignment of Benefits:

_____**(Initial)** Your signature below authorizes and directs payment of medical benefits to the practitioner for services provided to you by this office.

Release of Medical Records:

_____**(Initial)** Your signature below authorized the release of all of our medical records on file in this office for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance company that is paying your claims. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney. SOMA THERAPEUTICS, PLLC/ d.b.a (ALIGN360) is required, by law, to keep all client service records confidential.

Communication Permissions:

_____**(Initial)** Can we leave you a voicemail message? _____. Can we email you? _____

*My signature below affirms that I have read SOMA THERAPEUTICS, PLLC / d.b.a. (ALIGN360) 2020 Annual Update/Review of Key Policy Points. I have had the opportunity to ask question and discuss them. I agree to the stated terms and I have received a copy of this agreement upon request.

_____ _____

Client Signature **Date**