MASSAGE SOLUTIONS of Bend
. . . you deserve to feel this good

# ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

**Patient/Client Name:** ________________________________ **Date of Birth:** ______________

**Address:** __________________________________________ **Telephone:** ________________

**Your signature serves as acknowledgement that you understand and agree to the following:**

1. I am financially responsible for all services rendered by Massage Solutions of Bend, LLC.
2. I authorize the release of information, relating to any claim for services provided, to insurance carrier(s) or other parties responsible for payment of such claims.
3. I assign, and direct the insurance carrier(s) to make insurance payments directly to Massage Solutions of Bend, LLC.
4. If payment of service rendered is delinquent and the account is referred to an attorney or collection agency, I agree to pay the costs of collecting the unpaid charges, including, but not limited to, reasonable attorney fees and costs of suit.
5. Massage Solutions of Bend, LLC agrees to bill the insurance carrier(s) as a courtesy of the patient/client.
6. The patient/client agrees to furnish all information concerning patient's medical conditions to Massage Solutions of Bend, LLC.
7. The patient/client agrees to pay the co-payment obligation for each treatment.
8. The patient/client has the right to pay for each treatment, be given a receipt, and self-bill the insurance company.
9. The patient/client has the right to discontinue treatments at any time with prior notice of cancellation within a 24-hour time period.
10. The patient/client understands our 24-hour cancellation policy and will be responsible for payment for their service should they fail to keep or cancel all set appointments.
    **Please provide credit card for billing. **Initial _____**
11. The provider has the right to refuse service to anyone at any time.
12. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Massage Solutions of Bend, LLC will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to the Massage Solutions of Bend, LLC be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend and terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

**Patient/Client Signature:** ______________________________________ **Date:** _________

***UNDER 18 YEARS OLD? Sign Here***

***You signature below acknowledges that you understand the above and are declining Massage Solutions of Bend, LLC to bill your insurance carrier(s) for a period of no less than six months for the signed date below and agree that all charges are due immediately at the time of service.***

**Patient/Client Signature:** ______________________________________ **Date:** _________

**If under18 yrs. Guardian:** _____________________________________ **Date:** _________