

Jessica Gray, L.M.P.

Insurance Verification & Information

Patient Name: _____ Date of Birth: _____
Insurance Carrier: _____ ID/Claim #: _____
Group #: _____ Group Name: _____
Primary Insured & Relationship to: _____ Date of Birth: _____
Date of Injury: _____ Employer: _____
Claim Adjustor Name & Phone: _____
Insurance Verified: _____ online phone – name of ins. Rep: _____

Massage Covered: Yes No By LMP: Yes No In-Network: Yes No Out of Network: Yes No

Co-pay: _____ % Covered: _____

Deductible: \$ _____ Met for Year: \$ _____

Maximum Benefits for Massage: Is this a combined Outpatient Rehab Benefit?: Yes No

_____ Visits Per Calendar Year _____ Used to Date

\$ _____ Per Calendar Year _____ Used to Date

Referral Required from PCP: Yes / No Medical Necessity: Yes / No

The benefit acquired by The Center For Total Body Awareness, L.L.C., Jessica Gray, L.M.P. are not a guarantee of payment from your insurance company. Your insurance company may change your benefit payment at any time – please be aware of that benefits quoted may be different upon receipt of your explanation of benefits. As the patient, it is your ultimate responsibility to ensure you have benefit coverage for massage therapy before your first date of service. Contact your insurance company in order to obtain these benefits. Should payment be reduced or denied by your insurance company, you are responsible for payment on any balances due to The Center For Total Body Awareness, L.L.C., Jessica Gray, L.M.P..

Patient Signature: _____ *Date:* _____

Release of Information & Financial Policy

Permission to Bill Insurance:

The Center For Total Body Awareness, L.L.C., Jessica Gray, L.M.P. will bill directly to and is authorized to receive payment from my insurance company. In the event that the insurance company makes direct payment to me for services rendered, I agree to promptly send payment to The Center For Total Body Awareness, L.L.C., Jessica Gray, L.M.P.. I agree to make all copayments owed at the time of service.

Patient Responsibility:

The billing department will make all reasonable attempts to collect payments due. If they are unable to collect from my insurance company, I understand that I am responsible for all fees for services rendered. Also, it is my responsibility to verify that my provider is in my insurance network. It is my responsibility to call my insurance company and get benefit coverage information.

Release of Information:

I hereby authorized The Center For Total Body Awareness, L.L.C., Jessica Gray, L.M.P. to release information contained in my medical records to my insurance company for the express purpose of obtaining payment for services rendered in this office. I also authorize the insurance company or attorney to remit payment directly to The Center For Total Body Awareness, L.L.C., Jessica Gray, L.M.P.

Signature: _____ *Date:* _____