Colleen Shea Massage
4605 NE Fremont Street Suite 201-A
Portland, OR 97213
www.colleensheamassage.com
Colleen.s.shea@gmail.com
(415) 577-5787

FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE
Some insurance policies cover Massage and/or Acupuncture, but this office makes no representation that your policy does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Massage and/or Acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner. In the case that your insurance denies payment we will notify you via email and we will charge the credit card on file on a date that we have agreed upon after all efforts by our staff and yourself to collect payments have been exhausted.

PAYMENT ARRANGEMENTS
We require that you pay your copay
on the day the services are performed. Any unpaid balance will be considered past due after 30 days and may incur a late fee.

ASSIGNMENT OF BENEFITS

Attached is an “Assignment of Benefits” form which we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office within 30 days upon receipt.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above and I authorize payment for only the items outlined above via the card held on file, or at time of service, or within 30 days of receiving invoice of payment owed :

Your signature:____

Date signed:_________________________

Assignment of Benefits
Provider information
(where payment is to be sent)
Facility/agency or provider name: COLLEEN SHEA MASSAGE
Federal Employer Identification number: _______________________
Payment address: 4605 NE FREMONT STREET SUITE 201-A
City: PORTLAND
State: OREGON
Zip: 97213
Phone number: (415) 577-5787

Assignment of Benefits
You authorize payment to be paid to the provider shown above for insurance benefits otherwise payable to me. Insurance payments are normally made within 120 days, if we have not received payment within that time frame and all of our combined available efforts to obtain payments have been exhausted you understand that you are financially responsible to the named provider for the charges.
I certify that the information furnished in support of this claim is true and correct and I authorize payments to be made directly to COLLEEN SHEA MASSAGE.

Signature:____
(the insured's or the insured's legal representative) (Required)
Date signed:____________________