Extended Health Direct Billing / Release of Information Consent Form

In order to serve you best and ensure that we have all information needed to submit to your insurance and track payments on your behalf, we ask that you please fill out the below application form and submit it to us, prior to your massage therapy treatment.

Insurance Provider:

- ☐ Chamber of Commerce Group Insurance Plan
- ☐ Cowan Insurance Group (managed by Express Scripts Canada)
- ☐ Desjardins Insurance
- ☐ Great-West Life
- ☐ Industrial Alliance
- ☐ Johnson Inc.
- ☐ Other_____
- ☐ Manulife Financial
- ☐ Maximum Benefit or Johnston Group
- ☐ Pacific Blue Cross
- ☐ RCMP ☐ Veterans Affair Canada
- ☐ Standard Life Assurance Company of Canada
- ☐ Sun Life Financial

Client Full Name: _____ Plan No: _____ ID No: _____

Date of Birth (m/d/y): _____

Are you the primary extended medical benefits plan holder? ☐ Yes ☐ No *If not, please complete the following:*

Primary Holder's Name: _____ Plan No: _____ ID No: _____

Primary's Date of Birth (m/d/y): _____

Does your plan require a doctor's referral letter for Massage Therapy? ☐ Yes ☐ No *If so, please provide the same.*

Is your mailing address up to date both on file with us, and your medical benefits provider? ☐ Yes ☐ No *If no, please update this as soon as possible. Inconsistencies in your address may result in rejected payments.*

By completing this form and signing the below, you are applying for direct billing with our company. You are authorizing us to bill your medical benefits provider, on your behalf for therapeutic services rendered. You are consenting to the release of medical information by us to your insurance provider including but not limited to your full name, the dates and types of treatments provided. You understand that you are liable for all monies owed to us that are not covered by your medical benefits plan provider.

Client Signature: _____ Date: _____