

FINANCIAL AGREEMENT – HEALTH INSURANCE

Welcome. We are committed to providing high-quality, medically appropriate care. This document outlines how billing and financial responsibilities are handled.

INSURANCE COVERAGE

Insurance coverage for massage therapy varies by plan. We do not guarantee that your policy covers services provided.

You are responsible for:

- Deductibles
- Copay / coinsurance
- Any non-covered or denied services

As a courtesy, we will verify benefits when possible and submit claims on your behalf. If your insurance denies payment, you will be notified by email. The balance will be charged to the card on file 14 days after notification.

PAYMENT TERMS

- Copay is due at the time of service
- Any remaining balance is due within 30 days
- A valid card on file is required for all patients

ASSIGNMENT OF BENEFITS

By signing, you authorize payment of insurance benefits directly to this office. If payment is sent to you, you agree to remit the full amount to this office immediately.

RELEASE OF INFORMATION

You authorize the release of medical information necessary to process insurance claims and support medical necessity.

NO SHOW / LATE CANCEL / LATE ARRIVAL POLICY

A fee equal to 100% of the time-of-service rate will be charged if you:

- Do not reschedule at least 24 hours in advance
- Arrive more than 15 minutes after your scheduled start time
- Do not attend your appointment (“no show”)

This policy is outlined on our website and booking platform. Fees may be automatically charged. Insurance cannot be billed for missed appointments. All late fees are the patient’s responsibility. If you arrive late but within 15 minutes, your session may be shortened. Fewer than 4 units may be billed; deductible/copay/coinsurance still applies. Exceptions may be made for acute illness or emergency at provider discretion.

TERMINATION OF CARE

If care is discontinued for any reason, all outstanding balances are immediately due. All charges are billed to the card on file. You remain financially responsible regardless of insurance coverage.

We are happy to answer any questions regarding these policies.

PATIENT AGREEMENT

I have read and agree to the above financial policies. I authorize payment via the credit/debit card on file.

Signature: _____

Date: _____

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ASSIGNMENT OF BENEFITS

Provider Information

Julie Madsen / Caring Portland Massage LLC

FEIN: 84-3766009

PO Box 17431

Portland, OR 97217

Phone: 971-344-7895

I authorize payment of insurance benefits to the provider listed above for services rendered. If insurance payment is not received within 60 days, I understand I am financially responsible for all charges.

For Community Care Network / TriWest / Veterans Affairs:

I authorize the provider to submit claims on my behalf and accept direct payment from the third-party administrator.

I certify that the information provided is accurate and authorize payment directly to Julie Madsen, Caring Portland Massage LLC.

Name: _____

Signature: _____

Date: _____