IN TOUCH
massage and wellness

AUTHORIZATION TO PAY PROVIDER

I hereby authorize _____Insurance Company to pay by check and mailed directly to:

In Touch Massage & Wellness
1709 N. 8th Street
Bismarck, ND

For health care benefits allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay in a current manner, any outstanding balance that has not been paid by the insurance company or if it becomes overdue. I agree to pay finance charges on any outstanding balances older than 60 days at a rate of 1.5 % per month.

A photocopy of this authorization shall be considered as effective and valid as the original.

Dated _____ Name_____

Street address_____

City State & Zip_____

Insurance Information

Policy/Group #_____Claim #_____

Insurance Company:_____

Address:_____

Contact Agent_____Phone #_____

Date of Motor Vehicle Accident_____Referring Doctor _____

Letter of Prescription Attached: _____YES _____NO _____On file

Authorization to Release Information

I hereby authorize the release of any information acquired in the course of my examination & treatment to insurance carrier.

Date: _____ Signature: _____