Practitioner/Clinic Name: The Healing Spirit

Contact Information: Linda D Vessup,LMT

Office Policies

Client Information

Client Name: ______________________ Date: ________________ Date of Birth: ______________

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation

Amid the ongoing uncertainty of COVID-19, we have modified our cancellation policy to offer greater flexibility to all our clients. We hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule for whatever reason, and especially if you are not feeling well, we understand and request for you to please contact us as soon as possible to reschedule. To further support you, there will be no penalties for cancellations at this time.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

If this office is providing billing services, please be advised of our billing policies.

Cancellation

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits

Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: ________________________ Date: ________________