WINNING YOUR WELLNESS BACK

P.O. Box 634; Mesa, AZ 85211

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FINANCIAL AGREEMENT

Please read this agreement carefully. We will be happy to answer any questions you may have.

I, ______________________________ (client), understand that if I have insurance, it is an agreement between the insurance company and myself.

I understand that Winning Your Wellness Back (healthcare provider), will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are directly owed by me or denied by my insurance company.

I assign payments to be made on my behalf to this provider for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the sixty-first (61st) day. All payments owed solely by me are due at the time of service. There will be a $20.00 fee on any and all returned checks. Clients will pay 50% of scheduled appointment time for missed appointments not notified of cancellations 24 hours in advance.

In the event that my insurance company does not pay in full for services provided, I hereby authorize the health care provider to charge all past due payments to my credit card listed below.

In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I

____________________________ (client), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

SIGNATURE:______________________________________ DATE: __________________________________

CREDIT CARD #:___________________________________ EXPIRATION DATE: ______________________

Name as it appears on the credit Card: ____

INFORMED CONSENT

I, ______________________________, (client) understand that massage therapy provided by, Winning Your Wellness Back, is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes depending on individual need will be discussed and listed on the back of this sheet. These general benefits of massage, possible contraindications and the treatment procedure have been explained to me. I understand that massage is not a substitute for medical treatment of medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition that I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I have informed the therapist of all my known physical and medical conditions, and I will keep the therapist updated on any changes. I have received a copy of the therapist's policies, I understand them and agree to abide by them.

____ ______________________________

CLIENT SIGNATURE DATE