(Office Staff only) Client Name: LAST FIRST Client ID# Date Staff Initial

SKP Massage LLC-Financial and Insurance Policy-Please read the policy then sign and date at the bottom.

Payment is due at the times services are rendered. After 60 days of non-payment, a 10% interest fee will be added to your account to be compounded monthly. There is a $25.00 returned check fee, Plus any other applicable fees that may be incurred as a result of the returned check, which are to be paid no more than three (3) business days after the notification from SKP Massage LLC.

Please notify us by 4:00 pm on the day prior of any scheduling changes or cancellations, or you may be subject to a fee. Please see our cancellation and tardy policy for more information. We require a credit card to be on your file, to be charged for payment on a missed or late cancel appointment fee. You will be notified via phone and email prior to the charge. Please make sure you are enrolled in voice mail and or email to receive this message. You will be provided with an invoice for said charge (s), either by mail or at your next scheduled appointment. There will be a $5.00 billing fee if the Credit Card on file is denied for any reason, when processed for payment on a missed or late cancel appointment fee, unless payment is made within 24 hours of said occurrence.

I authorize SKP Massage LLC to charge the following card for any outstanding account balances due to missed or late cancelled appointments.

Credit Card information— Name on Card: ______________________________

Card #:______________________ Exp: _____________ CVV2#:________

Billing Address: ____________________State:_________ Zip Code:_______

SKP Massage LLC offers **PRIVATE PAY** services for our clients who are seeking generalized wellness care whom do not seek to utilize or do not have medical insurance coverage. Those clients are classified as *self-pay clients* and payment is due at each appointment. SKP Massage LLC accepts cash, personal check and all major credit cards.

It is our desire to assist our clients whenever possible. The following **insurance policy**, allows us to provide you with wellness care you need without the undue financial burden. Each insurance benefit package is unique and each client is advised to review their benefit statements for coverage details. Most insurance companies will only pay a percentage of your bill. It the responsibility of the client to remit any amount not covered by insurance.

1. If you have any form of an insurance reimbursement account, such as, but not limited to HSA or FSA, it is your responsibility to retrieve your money from that account. We will still expect payment when services are rendered.
2. If your wellness care is needed because of a work accident and you have a workman's compensation claim or personal injury claim due to an accident, please let our staff know, as additional paperwork may need filled out to process such claims for proper payment.
3. At the end of each year, we will provide, by request a free copy of your account payments and services rendered and any other medical records. Any additional copies will be provided, by written request, at $.10 per page. SKP Massage LLC will keep your records for seven (7) years. Any written request of client record from a previous year will be provided, at $.10 per page.
4. We will file for insurance payment at your request. This is a courtesy provided by our office. We reserve the right to withdraw this courtesy at any time, at our discretion. We will bill your insurance company and accept assignment of benefits for your wellness care. Direct assignment will be discontinued when your prescription or referral for wellness care has expired. We will notify you when this date is. If it is your desire to continue with wellness care past this date, it is your responsibility to acquire an updated prescription or referral. If you do not, or decide to discontinue medical massage services, you will be classified as a self-pay client, and payment will be due at each appointment.
5. It is your responsibility to know if you have a co-payment and the amount that it is. Your deductible amount must be paid by you in advance of the first billing. Also, you must stay current with your percentage of responsibility. This must be paid at least weekly. Prepayments are also accepted.

(Continued, Please sign on back…)

SKP MASSAGE

6. The insurance carriers are billed on specific 7-10 day cycles. It is your responsibility to provide SKP Massage LLC with any additional insurance forms needed to complete billing on your behalf. Social Security numbers are required by SKP Massage LLC for billing and financial services. By refusing to provide this information, you acknowledge that you may be refused service or be classified as a self-pay client.
7. If you receive payment from your insurance carrier during the period which the office has accepted assignment of benefits, you are to bring the check into this office within three (3) days of receipt and endorse it over to SKP Massage. Failure to do so may result in collection action. Provided, however, that if your delinquent account is turned over to a third party collection agency, then you agree to pay all collection costs, including, but not limited to, attorney fees and court costs.
8. If you discontinue your care for any reason, you will be responsible for any unpaid balance regardless of any claims submitted to your insurance company, at the time you discontinue your wellness care.
9. SKP Massage LLC does not guarantee that any insurance company will pay for your service. In the event that the insurance company disputes or rejects the claim, it will be the client's responsibility to pay for all the charges and pursue reimbursement from the insurance company on their own. The insurance company has thirty (30) days from the billing date to make this decision. Client payment is expected on any account balances over 30 days old.
10. I agree that SKP Massage LLC may release any medical or other information that I have provided them, that is necessary to process my claim to my insurance company/companies.
11. I understand that I am responsible for verifying coverage for medical massage therapy.
12. I acknowledge that I have been given a copy and fully understand my rights under the Notice of Privacy Policy, aka HIPAA.

*I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE POLICIES, *if client is a minor, this form must be signed by the Guardian who is financially responsible for said minor**

Printed Name : ______________________________ Signature : ________________________ Date:________

*Relationship to Client:_________________________ Minor's name (Client):_________________________

SKP
MASSAGE

Insurance Information— I hereby authorize _________________________ Insurance Company to pay:

SKP Massage LLC, P.O. Box 2623 Whitehouse, Ohio 43571 For any and all services performed and/or provided by their office.

Client: ____
S.S.#_______________________________D.O.B. _______________

Policy Holder:____
S.S.#_______________________________ D.O.B. _______________

Employer/Insurance Provided thru: ____

Group #: _________________________________ ID#: _________________________________

Insurance Phone #:____

Insurance Address: ____

Client authorizes SKP Massage LLC staff to deposit checks received on the client's account from the above insurance provider when made out to the client.