Direct Billing for Client Authorization Form

Massage on 194th
Unit 228, 803 Chaparral Drive SE
Calgary, AB T2X 0E5
403-873-9555

Client name: _____Phone:_____

Birth Date: Year_____ Month _____ Day_____

Insurance Company: _____

Plan/Policy/Group#: _____Certificate#/Member ID#:_____

Primary Member: Yes _____ No_____ If no please fill out the following:

Primary Member: First Name: _____Last Name:_____

Relationship to Primary Member _____

***If insurance does not go through, you will have to pay for your treatment. _____ (Initials)**

Consent to collect and exchange personal information

Purpose

Personal information that we collect and disclose about you, and if applicable, is used by the insurer, and/or plan administrator of your group benefits plan, its affiliates and their service provider(s) for the purposes of assessing eligibility for your claims, underwriting, investigating, auditing and otherwise administering the group benefits plan, including the investigation of fraud and / or plan abuse and for internal data management and data analytical purposes.

Authorization and consent

I authorize Massage on 194th to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize such insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits, or other benefits programs, other organizations, or service providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

(Please turn over to fill out reverse side)

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor, for that purpose.

If the client is a person other than myself, I confirm that the client has given their consent to provide their personal information for Massage on 194th and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

I accept the terms and conditions _____ (Initials)

Benefit assignment form

I hereby assign benefits payable for the eligible claims to Massage on 194th, who are responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to Massage on 194th. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to Massage on 194th for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this assignment will apply to all eligible claims submitted electronically by Massage on 194th and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to Massage on 194th.

I accept the terms and conditions _____ (Initials)

Date _____Signature of plan member_____

All information contained herein is protected by privacy laws including the Personal Information Protection and Electronic Documents Act (PIPEDA) and all the corresponding provincial legislation. All users agree to protect the personal health information contained herein from unauthorized use, disclosure, loss, theft, or compromise in accordance with the above noted laws and with at least the same care employed to protect their own confidential information. Any unauthorized access, disclosure or use of this information is illegal.