# Alice Halbert Registered Massage Therapy

## Direct billing Consent Form ( Electronic Authorization and Benefit Assignment)

Personal information that we collect and disclose about you, and if applicable, your spouse and or dependents, is used by the insurer and or plan administrator and their service provider (s) for assessing your claims, underwriting, investigating, auditing , and administering the group benefits plan, including the investigation of fraud and or plan abuse.

Authorization and consent I authorize my healthcare provider 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 re insurers, 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. 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 offense. If there is an over-payment, I authorize the recovery of the full amount of the over-payment 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 patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above. **I acknowledge that this is a courtesy service and in the event the therapist may not be able to submit my claim for various reasons , such as limited timing or doesn't have access to the program due to power outage or program updating , it is always my responsibility to provide payment**

- I accept the terms and conditions

Date : _____/_____/_____ Signature of plan Member _____

Name of Policy Holder:_____

DOB _____/_____/_____ (year/mm/dd)

Phone Number:

Address: _____

Spouse/Dependent ( if applicable)

DOB _____/ _____/ _____ (year/mm/dd)

Insurance company : _____

Plan /Policy number: _____

Certificate / Member ID _____

Physician Full Name : (required if prescription is needed):_____

Print name : _____

Signature:_____

Date: _____/ _____/ _____