Albert Barnes LMT

722 Holmes St NW F

Atlanta, GA 303018

License#: MT009566 NPI#: 1750925459 EIN#: 47-4629493

Insurance Billing Information

Name: (Last First MI)

_____

Address:_____

Date of Birth:_____

Primary Phone:_____

Email:_____

Insurance Company:

_____

Member ID#: _____

Group #:_____

You must have a referral /prescription from a Physician to receive massage therapy

Billing Policy

Albert Barnes, LMT is set up to receive direct payment from insurance companies. For

the best chance of reimbursements from your insurance carrier, I ask that you:

· Contact your insurance company to determine your massage therapy coverage and provider

stipulations. Coverage depends on your insurance company and the specific plan chosen.

· You may need a current prescription for massage therapy from a primary health care

provider for me to submit your claim.

It is important that you understand your insurance policies in order to take

financial

responsibility for your massage therapy sessions. **You are responsible for all charges**

incurred. **Payment in full is expected until your insurance coverage has been verified.**

Assignment of Benefits:

Your signature below authorizes and directs payment of medical benefits for services billed to your health care provider.

Release of Medical Records:

Your signature below authorizes the release of your massage medical records, including intake

forms, chart notes, reports and billing statements to your attorney(s), health care providers, and insurance case managers for the purpose of processing your claims.

Financial Responsibility:

It is your responsibility to pay for all services provided. In the event that your insurance company denies payment or makes a partial payment, you agree to be and remain responsible for the balance.

Cancellation/No Show Policy:

A 12 hour notice is required to cancel or change your appointment. Please text or email Bert directly to cancel and reschedule your appointment right away if something comes up.

Any late cancellations or missed appointments will be charged the price of the full session (the rate for Time of Service) prior to the beginning of the next scheduled appointment. You are financially responsible for any late cancel/no show fees, not your insurance company.

By signing below, you understand and agree to all of the above.

Patient Name (Please Print)

_____

Patient Signature (or Guardian) _____

Date _____

EMAIL COMPLETED FORM TO: BERT@BERTSMASSAGE.COM
FAX COMPLETED FORM TO: (770) 212-9772