WILD QUARTZ WELLNESS
massage therapy & holistic healing

FINANCIAL RESPONSIBILITY AGREEMENT

I, _____, understand that I am responsible for all charges incurred for my treatment at *Wild Quartz Wellness*. I consent that medical benefits from my insurance policy are paid directly to *Wild Quartz Wellness*, in consideration of services rendered up to the total amount of my account. Any balance remaining after insurance benefits have been paid is my responsibility. I will pay the balance within 60 days unless other arrangements have been made. I understand that in the event of default, my account will go to a collection agency. It is my responsibility to provide the correct insurance information. I will pay any balances resulting from inaccurate insurance information and I understand that I am responsible for all remaining balances. Every possible effort will be made to obtain payment for my claims. If the insurance company does not respond within 60 days I will pay in full and submit my receipt to get reimbursed from my insurance company. _____(initial)

- I authorize the release records necessary to process insurance claims.

  Signature _____ Date _____

  Print Name _____

- ALL COPAY AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.
- Appointments must be cancelled with 24 hours in advance.
- The fee for last minute cancelations is $50.00.

Patient Signature: _____ Date _____

Print Name: _____

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