**RELEASE OF INFORMATION**

|  |  |
| --- | --- |
| Client’s name: | Date: |

**Insurance Billing: (Optional)**

|  |  |
| --- | --- |
| Insurance Company: |  |
| Policy Holder’s name: |  |
| Policy/Group number: |  |
| ID number: |  |
| Other: |  |

I understand that payment for the services received is my responsibility. If my insurance company denies my claim or refuses to pay the full amount billed, I am responsible for paying the amount outstanding. I understand that the fee per visit for this service is based on time.

60 minutes $90.00 30 minutes $45.00 Additional 15 minutes $22.50

|  |  |
| --- | --- |
| Client’s signature: | Date: |
| RMT’s signature: | Date: |

**Confidential information sharing: (Optional)**

I give Dianna Bradley my consent to release or obtain information from the following individual(s) with respect to my treatment care by report, letter, phone, fax, e-mail or direct communication.

**Fill in name of professional** **Initials**

|  |  |
| --- | --- |
| Physician: |  |
| Insurer (company name): |  |
| Physiotherapist: |  |
| Chiropractor: |  |
| Other/Title: |  |

I authorize my RMT to contact my doctor or other health care professional listed above if required for treatment purposes. Any questions or concerns have been addressed to my satisfaction.

|  |  |
| --- | --- |
| Client’s signature: | Date: |
| RMT’s signature: | Date: |