Dianna Bradley, RMT

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phone: (902) 405-5335
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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 $86 30 minutes $43 Additional 15 minutes $21.50

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: