HHM Client Agreement & Health Release Form

Assignment of Benefits

I am responsible for all charges for all services provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance. I authorize and direct payment of medical benefits to my massage therapist, Happy Heart Massage LLC for services billed.

Signature_____**Date**_____

Release of Medical Records

I authorize the release of medical records or health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance ase managers, for the purposes of processing claims.

Signature_____**Date**_____

Contract for Care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of her skills and knowledge. I authorize and direct payment of medical benefits to my massage therapist, Happy Heart Massage LLC, for services billed.

Signature_____**Date**_____

Client agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage.
I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practioner of any changes in my health status.

Signature_____**Date**_____