AUTHORIZATION / FINANCIAL RELEASE

HIPPA AGREEMENT FOR NEW CLIENTS

I, ____________________, being a client of Holly Glennon RN/BSN, LMT, Nationally Certified Reflexologist, located at 1801 West Bay Drive, NW Suite #208B, Olympia WA, do hereby acknowledge that certain services may not covered by my insurance under the terms of my Health Plan. I understand that it is my responsibility to know and understand my insurance policy coverage and its benefits.

I authorize this office to release information regarding my care and treatment to my health plan and its agents for purposes of managing my health benefit payments to me and /or my practitioner. I hereby assign to this office any payments my Health Plan makes for services rendered to me and my eligible family members by this office by reason of its contractual relations with my health plan and its agents.

I understand that I am responsible to pay for services received at this office and I agree to make financial arrangements with my practitioner to pay for any services not covered by my insurance plan, including, but not limited to, any deductibles, co-payments, co-insurance, or charges for non-covered services.

I understand that most insurance policies cover one-hour treatments only. Any additional treatment time, over the one-hour customary limit, will be the client's financial responsibility at the time of that visit.

The following person(s) may receive disclosure of protected health information (e.g., information relating to the treatment, claims payment, and services provided to me by Balanced Bodycare, PLLC). Please list full names / phone numbers below:

Dated, ________________ (month) _______________ (day), 20___.

____

(Client signature)

Insurance Plan: ____

Member Identification Number: ____