

NAME (PRINT) _____

Referral Disclosure: Patients are responsible for providing a current referral or prescription from an authorized referring provider, dated within the past six (6) months, prior to receiving massage services. If an auto insurance carrier and/or L&I denies payment due to the absence of a valid referral or prescription on file, the patient acknowledges full financial responsibility for all charges incurred at Advanced Medical Massage.

Initial Here

Insurance and Billing Disclosure: All insurance claims, including MVA and L&I, must be approved and billable for massage treatment. MVA and L&I claims must be opened and authorized prior to treatment. Advanced Medical Massage's billing department periodically verifies claim information with insurance providers; however, the information available to us may be limited compared to what is accessible to you as the patient. For this reason, patients are strongly encouraged to independently verify their claim status and benefits. For MVA claims, only the patient may access the exact remaining balance of Personal Injury Protection (PIP) benefits unless an additional authorization is signed. Patients acknowledge responsibility for payment of services rendered if a claim is closed, denied, or benefits are exhausted.

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Tipping Acknowledgment: Massage therapy services at this clinic may be billed to Personal Injury Protection (PIP), Federal L&I, or Washington State Labor & Industries (L&I), when applicable. The clinic does not require, encourage, or expect gratuities for medical or insurance-billed services. If I choose to voluntarily express appreciation to a therapist, I understand that: (1) This is optional and not related to the cost, quality, or outcome of care, (2) It is not part of my medical bill and will not be submitted to any insurance or third-party payer, (3) It does not affect treatment decisions, scheduling, or provider availability. I agree not to request or expect any changes to treatment, documentation, or insurance billing in connection with any voluntary gift or gratuity.

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***Please note** - if your auto or work injury insurance rejects a claim, we do not bill health insurance in an attempt to cover any balances.

I have read the above and been informed that I may be responsible for the payment in full for today's appointment.

Signature _____

Date _____