DREAMCLINIC, INC.
CONSENT / RELEASE OF RECORDS/
ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT

CONSENT: **Client Initial Here_____**

I, the undersigned, hereby authorize the staff of Dreamclinic, Inc. to examine and perform procedures that are considered therapeutically necessary on the basis of findings during the initial exam and the course of treatment.

RELEASE OF RECORDS: **Client Initial Here_____**

To Dreamclinic, Inc.: I hereby authorize you and your chosen medical billing service, to release to any attorney, physician, State Insurance Commissioner, or insurance company, involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained on (date) ____/____/____.

ASSIGNMENT OF BENEFITS: **Client Initial Here_____**

To Insurance Company_____: I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf for medically necessary treatment.

Your denial or delay to do so in a timely manner will be considered just cause for the provider or me to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider to file this complaint on my behalf if deemed necessary.

CANCELLATION POLICY: Client Initial Here_____

I understand that at least **24 hours notice** is required for cancellation or rescheduling of appointments. For no-shows or cancellations with less than 24 hours notice I will be charged a standard cancellation fee. For visits where I am late, I will be charged a portion of said fee. My insurance will not be responsible for these charges.

PAYMENT AGREEMENT: **Client Initial Here_____**

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that Dreamclinic, Inc. is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to it for my medically necessary care and treatment.

I understand that Dreamclinic, Inc. charges the following rates for Medical Massage and Acupuncture (latest rates are on www.dreamclinic.com): Massage: $38 per unit (one unit is 15 minutes) and Acupuncture: $60 per unit (one unit is 15 minutes). Medical massage fees are based upon industry standard rates for Manual Therapy. Actual reimbursement rates vary due to Insurance companies' variances in allowable rates. I understand these charges are different from and above rates charged for Wellness services that are paid by clients directly.

I agree and acknowledge that I am ultimately responsible to Dreamclinic, Inc. for payment of any balance due and any cancellation fees that may arise. Balances may include any unpaid deductible, co-insurance, or co-payment due to Dreamclinic, Inc. according to my policy coverage, in the event the clinic is unable to collect from my insurance carrier or attorney, in the case where Dreamclinic, Inc. is holding an attorney lien on my behalf. Balances may also include fees for returned checks.

I, _____, a patient seeking health care, have assigned insurance benefits to Dreamclinic, Inc., a health care provider, for services rendered to me by him/her. **In addition to assigning payments to said health care provider, I have signed a financial agreement with said health care provider stating that I shall be fully responsible for any payments due to said health care provider that are denied by my insurance company.**

I have been given the opportunity to read the above CONSENT / RELEASE OF RECORDS/ ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT form, to ask questions concerning it, and have received an adequate explanation of it.

CLIENT NAME_____

(Please Print)

CLIENT SIGNATURE_____**DATE**_____/_____/_____

Revised January 2016