Center for Therapeutic Massage LLC
73 Walnut Street
Gahanna OH 43230-3025
(614) 476-8331

CONSENT TO TREATMENT, AUTHORIZATION TO RELEASE INFORMATION, STATEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

NAME _____

I authorize the facility and massage therapist(s) to provide massage therapy treatment and services to me.

The facility and massage therapist(s) have my permission to release any information needed for completion of their claims for payment from third-party payors, including, but not limited to: insurance companies, health maintenance organizations, preferred provider organizations, government agencies and their representative.

I permit release of information concerning dates of treatment, condition, diagnosis, procedures or surgeries to my personal physician, referring physician and/or the referring facility or for follow-up care. I am aware that this authorization to release information may include information regarding HIV or AIDS, alcohol or drug abuse and/or psychiatric treatment.

_____ Please initial to indicate approval of the above paragraph.

I acknowledge financial responsibility for all facility and massage therapy fees. I understand that the massage therapist will file my insurance claim if my massage therapist is a participating provider with my insurance carrier and I assign direct payment to the massage therapist all payments made under the terms and provisions of my policy. I understand that I am responsible for and will pay my portion of the unpaid balance due for services performed by the facility and massage therapist(s).

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____
(Consent for minors or others unable to give consent)

DATE _____