Heaven & Earth
Day Spa and Wellness Center
CLIENT & INSURANCE DATA

CLIENT INFORMATION:

NAME: _____SSN: _____ DOB: _____

ADDRESS/CITY/STATE/ZIP:_____
_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

CURRENT EMPLOYER: _____

INSURANCE INFORAMTION:
CLIENT'S RELATION TO INSURED: □ SELF □ SPOUSE □ CHILD □ OTHER

NAME OF INSURED: _____ SSN: _____ DOB: _____

ADDRESS/CITY/STATE/ZIP:_____
_____

INSURANCE CARRIER: _____

GROUP #: _____ POLICY ID#: _____

CLIENT SIGNATURE: _____ DATE: _____

Heaven & Earth
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Assignment of Benefits

To Insurance Company: ____AETNA/MERITAIN_____. I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf. This shall also serve as a "Limited Power of Attorney". Please provide them with any and all information regarding my policy benefits and coverages. Your denial of delay to do so in a timely manner will be considered just cause for myself or provider 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.
Client Initial Here: _____

Release of Records

To Provider of Services: **Heaven & Earth Day Spa and Wellness Center.** I have read and understand your Privacy Practices under HIPPA, and I hereby authorize you to release to any attorney, physician, or insurance company, involved in my case, any medical or other records or information necessary to process my claim. I understand these records may be utilized for t ultimate recovery of benefits in my case. **Client Initial Here: _____**

CLIENT'S NAME: _____

ADDRESS: _____

CLIENT'S SIGNATURE: _____DATE: _____

Heaven & Earth
Day Spa and Wellness Center
PO Box 2048
Windham, ME 04062
207-893-0033

Medical Massage Financial Agreement

Please read this agreement carefully.
We will be happy to answer any questions you may have.

I, _____ (client), understand that my insurance is an agreement between the insurance company and myself.

I understand that **Heaven & Earth Day Spa and Wellness Center** (provider) will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied or not paid by my insurance company. _____ (Please initial)

I assign payments to be made on my behalf to **Heaven & Earth Day Spa and Wellness Center** for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits to assist in the collection of payments for services. _____ (Please initial)

If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the sixty-first (61) day. _____ (Please initial)

In the event fees are not paid as requested, a collection agency and possible legal action may follow. If so, I, _____ (client), will be responsible to all reasonable costs associated with the collection of such fees, including attorney and court costs. _____ (Please initial)

I have read and understand this financial agreement.

Signature: _____ Date: _____

Heaven & Earth Day Spa and Wellness Center

Notice of Privacy Practices

In accordance with The Health Information Privacy and Accountability Act (HIPPA), all healthcare providers are required by law to maintain the privacy of your health information and proved you a description of their privacy practices. This notice identifies your rights regarding this center's use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by **Heaven & Earth Day Spa and Wellness Center.**

Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us and we will disclose health information about you to that doctor. For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your medical massage therapist needs to know about, while your medical massage therapist will share all findings with the prescribing doctor.

We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about treatment you are going to receive to determine whether you plan will cover it.

Information about your treatment and services may also be disclosed your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for the medical massage.

Although your health record is the physical property of **Heaven & Earth Day Spa and Wellness Center**, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions and medical and billing records.

If you believe that health information we have about you is incorrect or incomplete, you may request in writing that we amend your health information for as long as this office keeps information.

Our disclosure of your health information is limited to: this office, the physician who prescribed physical medicine, your insurance company your attorney, and you. If the client is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the client, and the client's health information will be disclosed to the parent or guardian.

If you believe your privacy rights have been violated, you may file a written complaint to the Office of Civil Rights in the U. S. Department of Health and Human Services at 200 Independence Avenue S. W., Room 509 F, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.

By singing this form, you hereby acknowledge that **Heaven and Earth Day Spa and Wellness Center** may release your Protected Health Information to carry out payment and treatment operations.

I have read and understand the Notice of Privacy Practices of **Heaven & Earth Day Spa and Wellness Center.**

_____ _____

Client/Client Representative Signature Date