MASSAGE AND BODYWORK

Jamie K. Lemmon *Licensed & Certified*

Balancing the Body, Mind & Spirit

Patient Information and Financial Responsibility

Full Name: _____
Address: _____
City, State, Zip Code: _____

Home Phone: _____ Work Phone: _____

Employer: _____

Birth Date: _____ Social Security Number: _____

Type of Injury: Work Auto Date of Injury: _____

Primary Insurance: _____
Address: _____
Agent Name: _____ Phone: _____
Policy and/or Claim Number: _____
Referring Doctor: _____ Phone: _____

Fee per treatment is $_____ Each treatment is _____ in duration. With the exception of the first visit and re-evaluations to be 1.5 hours at $ _____.

I hereby assign my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any medical records as requested and accompanied by a signed release. _____ **(initials please)**

IMPORTANT: ***If I fail to pay any balances when due and you incur attorneys fees and costs of collection to collect any balances, I agree to pay those reasonable attorneys fees and costs of collection whether or not suit is filed. I also agree that jurisdiction for any dispute shall be Aukeen District Court or the King County Superior Court, Regional Justice Center Kent.***

ALL UNPAID BALANCES SHALL BEAR INTEREST AT THE HIGHEST LAWFUL RATE OF INTEREST.

AGREED TO THIS _____ day of _____, 200___.

_____
(client signature)

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