Financial Agreement & Insurance

Please read this agreement carefully.
I am 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 Alix Marmulstein, LMT and Blissful Being Wellness, LLC, will assist me in billing my insurance carrier. However, I am fully responsible for any and all payments due that are denied by my insurance company or that of a third party.

I assign payments to be made on my behalf to this provider for any services furnished to me, in full. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

If the bills for services are not paid within sixty (60) days, after submission, by my insurance carrier, I am responsible for the balance on the sixty-first (61st) day. After sixty (60) days past last day of services issued, I understand that I may incur interest on past due payments in the amount of 15% per thirty (30) days past due from last date of service.

In the event that my insurance company does not pay in full for services provided, I hereby authorize Blissful Being Wellness, LLC to charge all past due payments to my credit card listed below. *By providing my credit card number, I understand that it is to be used for the purposes of this financial agreement only and that I will be notified about charges before there are made via email from Blissful Being Wellness, LLC. I am also aware that this document will be in a secure and locked file cabinet at all times.

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 for all reasonable costs associated with the collection of such fees, including attorney and court costs.

Upon signing, I affirm that I have read, understand, and agree to the terms above.

Signature: ______________________________________ Date: ________________

*Credit Card Number: ______________________________ Expiration Date: ________

Name of Cardholder as it appears on the Credit Card: _____________________________

Security code (CVC): ____________________ Billing Zip Code: ____________________

Insurance Information:

Name of at-fault party (for MVA):____

Insurance Plan: ________________________ Claim Number:______________________

Insured’s Policy Number: ___________________________ Date of accident: __________

Any other health benefits? Please give plan name and policy number below:

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