Release of Records, Payment Agreement, and Assignment of Benefits

Patient: _____ Date: _____

Insurance Company: _____

Referring Physician: _____

Attorney (if applicable): _____

I hereby authorize Jessica Bouton, Licensed Massage Therapy (hereinafter "LMT") and MedTherapy Solutions, LLC, **to release any and all medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s) if necessary, for the purposes of my therapeutic-related administration and evaluation, utilization review, outstanding debts, and financial audit. This authorization remains valid and effective from the date specified below, until revoked **in writing** sent certified return-receipt, to both my insurance carrier and to MedTherapy Solutions, LLC.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance, in a writing signed by an agent of MedTherapy Solutions, LLC and the patient. All professional services rendered are charged to me (*i.e.* the patient), and **I am responsible for all fees, regardless of insurance coverage.** I understand that I am responsible to MedTherapy Solutions, LLC for charges not recovered by this assignment, including deductibles and co-payments required by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expense of collection and/or court costs and reasonable attorney fees (currently $450 an hour). I also understand and agree that if my insurance has not paid for services provided to me by MedTherapy Solutions, LLC within sixty (60) days of my visit(s) that (1) I am responsible for payment of those services and will make arrangements **to pay all unpaid charges within five (5) days** and (2) that no further services will be rendered to me, until all unpaid charges are paid in full.

Assignment of Benefits: I hereby assign Jessica Bouton, LMT/ MedTherapy Solutions, LLC, all money to which I am entitled to for therapeutically-related services, received at or through MedTherapy Solutions, LLC. The payment shall not exceed my indebtedness. Any proper and correct payment (*e.g.* non-erroneous or over-paid amounts) received by MedTherapy Solutions, LLC from my insurance carrier beyond my indebtedness to MedTherapy Solutions, LLC (*e.g.* co-payments paid or payment(s) for services in advance of submission of insurance), shall be refunded to me, when my outstanding indebtedness to MedTherapy Solutions, LLC is paid in full.

I understand that I can request a copy of any or all of my therapeutic records for a reasonable fee, as permitted by state law. A copy of this document shall be valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. **The payment agreement portion of this instrument may not be revoked in writing or otherwise.**

Signed: _____ Date: _____