**Direct Billing Consent, Authorization and Acknowledgement**

**Consent to Collect and Exchange Personal Information:** I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer/plan administrator and their service providers for the purposes of assessing my claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud/plan abuse. I confirm I have consent from the primary insured plan member (if not myself) to collect, use and disclose any personal information about them for the same reasons as stated above.

I hereby authorize my health care provider to directly bill my insurance company on my behalf for services provided at Massage Therapy Niagara. I acknowledge that if my claim is not paid in part or whole, or is not paid directly to the health care provider, that I will pay any balance owing immediately after treatment. In some cases my credit card information may be saved to my profile (PCI compliant) so that if the health care provider needs to wait on payment details, my credit card can be charged at a later time for any balance owing.

| ____________________ | ____________________ | ____________ |
| --- | --- | --- |
| Print name | Signature | Date |