**Release of Records, Payment Agreement, & Assignment of Benefits**

Patient: Date:

Insurance Company:

Referring Physician:

Attorney (if applicable):

**I hereby authorize** Kneading Touch, My Health Care Provider/Facility, **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 payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked **in writing**, to both my insurance carrier and to the provider of services.

**Payment Agreement**: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient, and **the patient is responsible for all fees, regardless of insurance coverage**. I understand I am responsible to the above mentioned provider/facility for charges not recovered by this assignment, including deductibles & co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and/or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider/facility, I am responsible, and I will then make whatever arrangements are necessary and available to me **to pay all unpaid charges**.

**Assignment of Benefits**: I hereby assign Kneading Touch, My Health Care Provider/Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned provider/facility. The payment shall not exceed my indebtedness. Any payment received by the above mentioned Health Care Provider/Facility from my insurance carrier beyond my indebtedness to the above mentioned Health Care Provider/Facility shall be refunded to me, when my outstanding bill(s) with them are paid in full.

I understand I can request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Worker’s Compensation Statute. Any copy of this document shall be as 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 potion of this instrument may not be revoked in writing or otherwise**.

Signed: Date:

Printed Name:

Witness: Date:

Printed Name: