

Holistic Massage & Wellness Clinics, Inc.

Insurance Verification Form

Sarah- Insurance Manager C:(860) 803-9097 F:(954) 722-6676

Approval can take up to 72 hours. Please be as detailed as possible to expedite approval process.

Name: _____ Phone Number(s) H: _____
W: _____
Address: _____ C: _____

Date of Birth: _____

Emergency Contact: _____ Phone: _____

PIP Worker's Comp (WC) Complimentary Billing (CB)

Insurance Company: _____ Adjuster Name: _____
Policy Number: _____ Insurance Co./
Adjuster Phone: _____
ext: _____
Claim Number (PIP/WC): _____
Group Number (CB): _____ Attorney Name:
(if applicable) _____
Date of Accident: _____ Attorney Phone: _____

Please fax all information to Sarah at (954) 722-6676:

- Insurance Verification Form (page 1)
- Medical Release Form (page 2)
- copy of Driver's License
- copy of Insurance card (comp billing only)
- copy of Prescription from Doctor, if available

For Office Use Only

Deductible: _____
Med Pay: yes no
Once met payment at _____ %
Policy Limit: _____

Date Verified: _____

Holistic Massage & Wellness Clinics, Inc.
POWER OF ATTORNEY AND MEDICAL RELEASE

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PIECE OF PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS / AUTHORIZATION TO PAY.

Know by all these present that: The undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint Holistic Massage & Wellness Clinics, Inc., and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place and stead to endorse any and all checks, drafts or money orders which are made payable to the undersigned alone or to the undersigned and the said Holistic Massage & Wellness Clinics, Inc., which checks, drafts or money orders are made payable for services which have been made by Holistic Massage & Wellness Clinics, Inc., at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft or money order.

Furthermore, the undersigned allows Holistic Massage & Wellness Clinics, Inc., or any of its agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements.

The undersigned by these presents does give and grant the said Holistic Massage & Wellness Clinics, Inc., as attorney the full power and authority to do and perform all and every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as the endorsing and cashing of said checks are concerned as well as any other document.

MEDICAL RELEASE

A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of the same to Holistic Massage & Wellness Clinics, Inc., or any insurer providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page.

The undersigned does hereby ratify and confirm any and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize _____
(Name of Insured/Patient) (Name of Insurance Carrier)

to make medical benefits payments otherwise payable to me for services rendered by Holistic Massage & Wellness Clinics, Inc., but not to exceed the charges of those services, payable to and mailed directly to:

HOLISTIC MASSAGE & WELLNESS CLINICS, INC.
570 OCEAN DRIVE #501
JUNO BEACH, FL. 33408

I hereby instruct the insurance carrier that in the event the subject medical benefits are disputed for any reason, including medical reasonableness and/or necessity, that the amount of unpaid benefits claimed by Holistic Massage & Wellness Clinics, Inc., is to be set aside and not disbursed until the dispute is resolved.

Furthermore, I hereby IRREVOCABLY ASSIGN to Holistic Massage & Wellness Clinics, Inc., the rights and benefits and any and all causes of action resulting from non payment under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Holistic Massage & Wellness Clinics, Inc.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____ day of _____, _____.
(day) (month) (year)

PATIENT'S SIGNATURE

PATIENTS NAME (PLEASE PRINT)