Electronic Transmission Authorization Consent Form

Your Name________________________________

Your Phone #______________________________

Your Provider______________________________

Your Policy #______________________________

Your ID#__________________________________

I authorize Nicola Valley Massage Therapy Clinic to direct bill and collect payment for my treatment on my behalf. I agree that if for some reason my provider does not cover some or all of my treatment costs, I will be responsible for the full amount owing.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

Print Name____

Signature____