

Bowenwork® Northwest

Payment and Insurance Information

Name: _____ Date: _____

Bowenwork® Northwest (a div. of MBNW, Inc) **offers TWO options for payment:**

OPTION 1 Paying out-of-pocket, and/or, you do not have insurance, and/or you will be submitting your receipts to insurance for re-imbusement.

OPTION 2 If you have one of our "ACCEPTED" insurance carriers.

OPTION 1 NO INSURANCE COVERAGE or PATIENT BILLS NSURANCE

Fees:			Discount for payment at time of service
Initial Assessment and Treatment:		\$140.00	\$85.00
Bowenwork® Session:		\$140.00	\$70.00
Wellness package (4 sessions):		\$560.00	\$250.00

I would like a receipt with each visit to submit to my insurance company

YES NO

I agree to pay out-of-pocket for my care:

Signature: _____ Date: _____

OPTION 2 INSURANCE BENEFITS ACCEPTED

We currently bill the following insurance companies with a Doctor's Referral/Prescription:

Regence Blue Cross/Blue Shield

Premiera/Blue Cross

Aetna

Cigna

Corvel

Uniform Medical Plan (UMP)

L & I

Personal Injury Claims for Motor Vehicle Accidents

If your insurance company is not listed above then we will be happy to give you a receipt for you to submit to your insurance company for reimbursement. Please go to OPTION 1.

Insurance Company: _____

Insured's Name: _____

ID #: _____ Group#: _____

(Please present your insurance card so we may have a copy in our records)

Do you have a Doctor's referral or prescription to receive massage/manual/physical therapy?

YES

NO

(Please give us the Doctor's referral for our records)

Please complete backside →

Please read the following terms and initial each one. Sign at the bottom.

1. _____ **Our fee per session is \$140.00.**

If you would like us to bill your insurance company to meet your deductible, the full amount of the \$140.00 will be charged and due at the time of service.

2. _____ **I agree that my insurance benefits must be verified and a physician's prescription or referral must be received prior to Bowenwork Northwest (a div. of MBNW, Inc) beginning treatments or billing my insurance for re-imbusement.**

Our office policy requires that insurance benefits must be verified and in most cases, a physician's prescription be given to us, BEFORE we will begin treatment or bill your insurance for payment of services. Payment at the time of service is expected until all information is received in order to process your insurance claims.

3. _____ **I agree to meet the expectation's of my physician's referral.**

It is our office policy to meet the expectations of a physician's referral and prescription for care indicated. Therefore, we require you to be consistent with your treatment plan; otherwise, we reserve the right to discontinue your care. If you feel that you have reached maximum benefit with Bowenwork® prior to the expiration of your prescription, please discuss this with the practitioner. If both you and the practitioner agree that you have reached maximum improvement, and assessment/examination will be given and a final report will be sent to your physician. It is also your responsibility, the patient, to receive continued referrals for care.

4. _____ **I agree that I am responsible for all fees and for services rendered through Bowenwork® Northwest (a div. of MBNW, Inc). I take full responsibility for any unpaid services that my insurance carrier does not cover.**

I understand and agree to all of the above terms and agreements.

Signature: _____ Date: _____

(rev. 07/16/2008)