CONSENT TO DIRECT BILLING

Last Name: _____ First Name: _____

Email Address (required):_____

Extended Health Carrier: _____

Policy/Plan Number: _____ Member ID: _____

Primary Plan Member (if not same as patient):_____

Primary Plan member DOB: _____

Relationship to Primary Plan Member: _____

Area of Body Being Treated: _____

I, _____ (Beneficiary) authorize _____ (Extended Health Carrier) to pay Vancouver Physiotherapy and Sports Clinic directly for all reimbursements payable to me by my extended health benefits plan for care provided to me by my registered physiotherapist and/or registered massage therapist.

INFORMATION REGARDING DIRECT BILLING

- All expenses not covered by the extended health carrier are the patient's responsibility. We ask that your account balance is paid at the end of each visit.
- If your carrier requires you to have a Doctor's referral for treatment you must provide the clinic with a copy of the referral before we can direct bill your carrier.
- Vancouver Physiotherapy and Sports Clinic will bill 1(one) third party payer per visit. We will provide you with a copy of the Explanation of Benefits to submit to any other carriers.
- Vancouver Physiotherapy and Sports Clinic will not bill extended carriers for missed appointment fees.

Signature of Patient: _____ Date: _____