

SIGNATURE ON FILE FORM

I authorize Dmitriy Gushchin, L.M.T. to release to any insurance company, adjuster, or attorney involved in this case, any medical or other information needed to process this or any related claim.

Client's Signature _____ Date _____

(Note to client: It is common for insurance companies to ask massage therapists for a description of the procedures they deliver. Your signature above gives me the right to provide such information as I may have on your condition and treatment, to your insurance company. I will give such information only to your insurance company, and only when they request it to help them process your claim.)

I authorize payment of insurance benefits to Dmitriy Gushchin, L.M.T.

Policy holder's signature _____ Date _____

(Note to policy holder: Your signature above means that your insurance company will pay claims for my services directly to me, not to you. If you want insurance payments to go to you, I must be paid at the time of service, and you must collect the insurance claim on your own.)

If my current policy prohibits direct payment to the therapist, than I hereby instruct and direct you to make the check out to me and mail it as follows:

Dmitriy Gushchin, L.M.T.
651 Boylston St., 2nd floor
Boston, MA 02116.

Policy holder's signature _____ Date _____

(Note to policy holder: Your signature above means that if your insurance company prohibits direct payment, it will then make the check payable to you and will send it to my office.)

I authorize a copy of this authorization to be used in place of the original.

Client's Signature _____ Date _____

Policy holder's signature _____ Date _____

(Policy holder's signature is needed only if the policy holder is not the patient.)

(Note to policy holder: Your signature above allows me to put the words "Signature on File" on claim forms. If you don't sign this, you'll have to sign each claim form I submit on your behalf.)