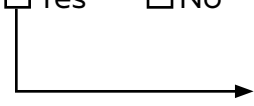
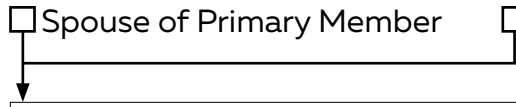


Direct Billing Authorization



Please print clearly.

Since the motor vehicle accident, have your injuries been assessed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please indicate which health care provider conducted the assessment: <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Chiropractor	
Name of the facility that conducted the assessment:	
Has the health care provider referred you for Massage Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have extended health benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	
Insurance Company	Member ID
Policy #	Your Date of Birth
Are you the primary insured member on this plan? <input type="checkbox"/> Yes <input type="checkbox"/> Spouse of Primary Member <input type="checkbox"/> Child/Dependant of Primary Member	
 Primary Member's Name	

I declare that the information provided is true and accurate to the best of my knowledge. I am responsible to immediately update Muscle Matters of any and all changes to my insurance coverage, treatment plan, etc.

I authorise Muscle Matters to direct bill my insurance company for my massage therapy treatments.

I understand that I am responsible for paying for my treatment should coverage be denied for any reason by my insurance company.

Signed _____ Date _____

Print Name _____