MONADNOCK Myofascial Release

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Insurance Intake Form

I hereby authorize Monadnock MFR to release any information, relevant to obtaining insurance reimbursement, acquired in the course of my exam and treatment sessions to your insurance company. I understand that any information regarding my insurance coverage provided to me by Monadnock MFR or their billing agency is done as a courtesy, and that I am completely responsible for knowing my insurance coverage and keeping it up to date and on file.

I also assign and request payment of medical benefits to Monadnock MFR for Occupational Therapy services. I also understand that I am financially responsible for any charges not covered, for any reason, by said insurance company. I understand that I will be billed for this amount, and that the billed amount is due in full upon receipt. I also agree to be responsible for payment of any fees or services required to collect any unpaid bills.

Patient Signature:_____ Date:_____
Please print your name:_____

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