BODYWORKS MASSAGE CLINIC
Patient Financial Responsibility & Insurance Disclaimer Form

Patient Name: _____
Date of Birth: _____
Date of Service: _____

Insurance Disclaimer & Payment Responsibility
Please read and sign below to acknowledge your understanding of the following policy:

1. **Health insurance is not a guarantee of payment.**
   While we may bill your insurance as a courtesy, final payment responsibility rests with **you, the patient**.
2. **You are responsible for any services not paid by your insurance company.**
   This includes deductibles, co-pays, co-insurance, denials, or any uncovered services.
3. **BODYWORKS MASSAGE CLINIC and your insurance provider have separate financial agreements.**
   Your insurance company **cannot instruct you to withhold payment** for services you've received.
4. **If you received care, you are responsible for paying for it.**
   Regardless of your insurance company's decisions or delays, **payment is due for all services rendered** by your massage therapist.

Acknowledgment & Signature

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined above. I understand that I am responsible for any portion of my bill not covered or paid by my health insurance provider.

Patient Signature: _____
Date: _____
Printed Name: _____