Better Health Clinic

Before continuing, please note the following:

* Direct Billing is currently limited to Massage and Naturopathy for the following insurance companies: *Chamber of Commerce Group Insurance, Cowan, Great-West Life, Industrial Alliance, Johnson Inc., Manulife Financial, Maximum Benefit or Johnston Group, Standard Life, Sun Life Financial.*

* There is no guarantee that your policy will, 1) allow for direct billing, or 2) cover the full amount.

* If the full amount is not covered, the remaining balance will need to be paid up front.

* Any issues with direct billing will need to be sorted out directly with your insurance company.

* Direct billing cannot be used to make payment for anyone other than the policy holder.

Patient Information:

Patient First Name:_____ Last name:_____

Address: _____ City/ Province: _____

Postal Code:_____ Phone Number: _____

Date of Birth: (Y) _____(M) _____(D) _____

Primary Coverage Information:

Relationship to Member: _____ Date of Birth. (Y)____(M)___(D)____

Plan Member's First Name:_____ Last name:_____

Insurance Co:_____

Policy:_____ Member ID:_____
(approx. 6 Characters) **(approx. 11 Characters)**

Secondary Coverage Information:

Relationship to Member_____ Date of Birth. (Y)____(M)___(D)____

Plan Member's First Name_____ Last Name:_____

Insurance Co:_____

Policy:_____ Member ID:_____
(approx. 6 Characters) **(approx. 11 Characters)**

Benefit Assignment Form

Additional Claim Information

Is this an injury caused by an accident?

Yes ☐ No ☐

Was this service prescribed or a referral?

Yes ☐ No ☐

By Physician First Name: _____ Last Name:_____

Certificate / Plan member Number: _____

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____

Date: Signature

Print Name:

Electronic Transmission Authorization and Consent Form

Consent to Collect and Exchange Personal Information
Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my health care provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including health care professionals, investigative agencies, insurers and re-insurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the health care provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an over payment, I authorize the recovery of the full amount of the over payment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

_____ _____

Date: Signature

Print Name: