AUTHORIZATION FOR DIRECT ON–LINE BILLING

Insurance Provider: ____

Policy Number: ____

Primary Cardholder	**Spouse or Child Cardholder**
______________________________ Name	______________________________ Name
______________________________ Date of Birth	______________________________ Date of Birth

I, ____ (client) hereby authorize the Registered Massage Therapist (RMT) ____ to submit personal information to my insurance company and / or WSIB as necessary for direct on-line billing using a computer, tablet or smartphone, for claims adjudication and to exchange information with other parties as required and only when the information is needed to administer this benefit claim and / or to confirm the accuracy of this information.

By my signature below I acknowledge that payment of any and all on-line submissions made on my behalf be directly paid to the provider of said service and that any outstanding debts whether treatment or otherwise not covered by my insurance company and / or WSIB will be my responsibility.

______________________________ **Subscriber Signature**	______________________________ **Date**