Direct Billing Letter

Dear Patient,

We are happy to set up direct billing to your current extended health provider. We hope this saves you the time and energy of having to do the billing yourself as we all know how busy life can be. However, with us taking on this new task, there a few requirements you need to read carefully:

1. You will need to provide us with a signed consent, and a Visa or Mastercard number to be securely placed on file in order to bill you directly in the event that your extended health provider later denies or reduces coverage on a claim. Once you sign the consent, your card will be billed automatically for any outstanding expenses and a receipt will be emailed over to you. **Please note that if you choose not to sign the consent or provide us with a Visa or Mastercard number to be securely housed on site, we cannot direct bill for you.**
2. Please be aware that some extended health providers require a doctor's note for health services to be billed directly. You are responsible for ensuring this updated note is on file with us if it is required. In this case, if you do not have a note or it expires, we will have to bill you the full cost of your visit until a new note is provided.
3. Your health care provider may not provide 100% coverage of a visit i.e. they may only provide 80%, which means you will be asked to pay whatever amount is remaining at the time of visit.
4. If for some reason, we are unable to get a response from your extended health provider for your visit, the full amount of the visit will be charged at the time of visit.
5. Deductibles must be paid yearly with many extended health care plans. Deductible costs can vary across all plans and so you may be required to pay that deductible at one of your visits with us if it has not been paid elsewhere for the current calendar year.
6. Please ensure that even if you have direct billing set up with us that you check in with the front desk before you leave from your appointment so that we can inform you of any changes to your billing or monies owed to us.

I have read and fully understand the requirements set out above by Whole Body Health and Wellness in regards to the direct billing of my account with them. I further provide my consent to the centre to bill my extended health provider, __________________________, on my behalf. I also understand that if any information changes to my account, I must provide the updated information to the centre in a timely manner.

_______________________________ ________________________________

Patient Name (Printed) Patient Signature

Date : ____________________________

CONSENT, AUTHORIZATION, AND DIRECTION TO PAY

(the "Consent")

TO: WBH & WELLNESS CENTRE INC.
doing business as "WHOLE BODY HEALTH AND WELLNESS"
#105, 11862 226th Street, Maple Ridge, BC, V2X9C8
Ph: 604-479-0777
(the "Centre")

I, Name:______________________________________,
Address:____, British Columbia, ______________,
Date of Birth:___________________,
PHN:__________________________,
(the "Patient") HEREBY:

1. CONSENT, AUTHORIZE, AND DIRECT the Centre to use the following payment information to pay for any outstanding account held by the Centre on my behalf (the "Account"), in the circumstance where a third party coverage provider, or third party coverage providers have, denied payment coverage for the Account:
   [Patient Information]
   Full Name: ___________________________________
   Address: _____________________________________
   Phone number: ________________________________
   Name on Credit Card: _________________________________
   Credit Card Number: __________________________________
   Credit Card Expiration Date: ___________________________
   Credit Card Security Code: ____________________________

2. FURTHER ACKNOWLEDGE that I am responsible for final and full payment of the Account.

3. RELEASE the Centre, and the Centre's employees and agents, from any and all actions, suits, payments, claims and demands whatsoever in law or equity, which may now or hereafter may arise as a result of this Consent.

4. DECLARE that I have read and understand this Consent.

5. DECLARE that I am over 19 years of age at the time of signing this Consent, or that I have legal authority to act on behalf of the Patient and am over 19 years of age at the time of signing this Consent.

This Consent may be signed by facsimile or .pdf email electronic transmission, and each such facsimile or .pdf email electronic transmission copy shall constitute an original document.

DATE: ______________________, 20___.

Signed, Sealed and delivered
in the presence of:

____
Name

____
Address
____

____
Occupation

____
Print Name:

____
Legal Authority (if applicable, ex. Guardian)