▪ 10030 King George Blvd, Surrey BC ▪ www. Physiozone.ca ▪ info@physiozone.ca ▪ 778 771 4123

CANCELLATION POLICY

Our goal is to provide quality treatment care in a timely manner. Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Please be courteous and call us at 778-771-4123 or send an email to info@physiozone.ca promptly if you are unable to attend your appointment with your name and appointment details. Clients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee at the price of their missed appointment. I hereby declare that I have read and understood PhysioZone Health Inc. Cancellation policy.

Client / Authorised Party Signature	Date

BILLING AGREEMENT.

I have read the posted fees and agree to pay those fees for treatment. I understand that payment for all the treatments, whether private or insured, is the ultimate responsibility of the client. It is the client's responsibility to keep track of their claim status and numbers of visits that have been approved. Any fees not covered or refused from any third party or insurer is immediately due to the clinic at the private rates posted above. I understand that any outstanding balances are due before I may start my next treatment.

Client / Authorised Party Signature	Date

EXTENDED BENEFITS AUTHORISATION.

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. If my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Service Provider (Practitioner at PhysioZone Health Inc.) for their supplies, goods and services rendered. I understand that this assignment will apply to all eligible claims submitted electronically by the Provider (PhysioZone Health Inc.) 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 the plan member authorizes me to execute an assignment of benefit payments to the Provider (PhysioZone Health Inc.)

Client / Authorised Party Signature	Date

CONSENT FOR RELEASE OF INFORMATION (To Lawyer, Funder, Insurance Company, Doctor Offices, Imaging Department)

I hereby consent and authorize PhysioZone Health Inc. to contact my lawyer, funder or insurance company, Doctor offices and Imaging department, either by phone, fax, mail, or e-mail, to facilitate appropriate assessment, treatment, or other services as I may require.

Client / Authorised Party Signature	Date