Vivie Therapy

REBUILDING YOUR BODY, MIND AND SPIRIT BACK-TOGETHER
8818 Saturn St. Los Angeles CA 90035
(310) 623-4444 www.Vivie.com

Patient Name: ___________________________________

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for Vivie Therapy to furnish care and treatment considered necessary and proper in treating my condition.

Authorization for signature on file and release of information

I, the undersigned, hereby authorize the office of Vivie Therapy to affix my name to any and all claims or documents as related to any and all health care received by me at Vivie Therapy associated with treatment at Vivie Therapy and relating to my health care claims incurred at Vivie Therapy. A photostatted copy of this authorization shall be as valid as an original. I also authorize Vivie Therapy to release any records pertaining to treatment rendered here to any insurance company, insurance adjuster or attorney involved in the case.

Assignment of Benefits

I hereby instruct and direct my Insurance company to pay insurance benefits by check directly to:

Prevent The Pain Therapy DBA Vivie Therapy
P.O. Box 6520
Beverly Hills, CA 90212

This assignment is for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by Vivie Therapy. This payment will not exceed my indebtedness to above-mentioned assignee, and I have agreed to pay and be financially responsible for, in a current manner, any deductible, co-payments or any balance of said professional service charges over and above this insurance payment.

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Vivie Therapy. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. By signing this agreement, I am personally responsible for any and all monies owed to Vivie Therapy in the event that my said insurance company fails to pay for any or all charges for services rendered. I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting monies owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

Cancellation Policy

I, the undersigned, am aware that specific time is reserved for me when I schedule an appointment. If I cannot keep my scheduled appointment, I must give at least 24 hours notice so that you may reschedule my appointment and offer the reserved time to another patient. I agree to pay a charge of $75 for NO SHOW appointments and $50 for cancellations with less than 24-hour notification unless waived by an authorized person at Vivie Therapy. I, the undersigned, understand that and I will be personally responsible for any cancellation fees.

I agree that all exercise and the use of this fitness facility are undertaken by me at my own risk and Vivie Therapy as well as Vivian Eisenstadt shall not be liable for any claims of injuries or damages whatsoever, arising out of or connected with the use of their facility. I agree to hold Vivie Therapy and Vivian Eisenstadt not responsible for any claims or negligence.

Dated in Los Angeles, California, this _______ day of ______________, 20_____.

_____________________________________ ____

Signature of Policyholder/Patient **Signature of Claimant if other than Policyholder**