



P. Leilani Berry, LMP
leilani@leilanimassage.com
www.leilanimassage.com
206-914-3885

Payment Policies

- Please choose one of the following payment options.
- Auto accident and on the job injuries please check the additional box.
- Please ask if you have any questions.

Same Day Pay - Massage \$35-155

You pay the same day as the massage is performed and you receive an administrative/bookkeeping discount.

Billed Rate - Massage \$30-120

We bill your insurance company, auto insurance, the Dept. of Labor of Industries, or a third party. Applicable co-pays are due at the time of service. If you have a deductible or a percentage arrangement with your insurance plan, we will bill you at a later date. Applicable percentages and deductibles will be billed when the insurance company pays their portion and sends us an explanation of your portion. We contract with every major insurance company in Washington, and we will NOT bill you for the any difference between our rate and the contracted/adjusted rate as a preferred provider. The exceptions are the applicable co-pay, deductibles, percentage arrangements, and “patient portion” as outlined and explained by your insurance company.

On the Job Injuries

If your claim is allowed, we will bill for services and you pay nothing. If your claim is denied or closed, you are responsible for all the applicable charges.

Auto Injuries

We will gladly bill your auto insurance company. If the responsible party is someone else's auto insurance company or in the case of delayed payment, we will require lien against your settlement for the delay in payment. In either case, you are responsible for any charges that are not paid for by insurance.

By signing this, I give my permission to the office of P. Leilani Berry, LMP to release my medical information or other information necessary to process my billing. In the case of billed rates, I request payment by made directly to the office of P. Leilani Berry, LMP. I have read the above and have been given an opportunity to have my questions answered.

Patient Name: _____

[Print Name]

Signature of Patient or Adult in case of Minor

Date