THIRD PARTY BILLING PERMISSION FORM

I, _____, client at Revelation Massage Therapy & Wellness and insured member of _____, do authorize Revelation Massage Therapy & Wellness to collect payment on my behalf, directly from the above insurer for massage therapy service rendered at:

Revelation Massage Therapy & Wellness
119 Perry Street, Unit #1
Port Perry, ON
L9L 1B8
905.982.8799

Signed:_____

This _____ day of _____, 20_____.

For office use:

RMT:_____
Signed:_____
This _____ day of _____, 20_____.