Kyanne Stennett
MASSAGE THERAPY

Direct Billing Information Form

Please complete this form to allow your Registered Massage Therapist to submit direct billing claims to your extended health benefits provider (where available). All information will be kept confidential and used solely for the purpose of submitting claims related to massage therapy services.

Employee Information

First Name _____

Last Name _____

Date of Birth (YYYY-MM-DD) _____

Email Address _____

Insurance / Benefits Information

Benefits Provider (e.g., Sun Life, Manulife, Green Shield, etc.) _____

Member ID / Certificate Number _____

Policy / Plan Number _____

Consent for Direct Billing Submission

I hereby authorize **Alisa Kyanne Stennett of Kyanne Stennett Massage Therapy** to collect and use the personal and insurance information provided above for the purpose of submitting claims to my extended health benefits provider, on my behalf, for massage therapy services rendered. I understand that:

- Direct billing is not guaranteed and depends on the policies of my benefits provider.
- I am responsible for any balance not covered by insurance.
- My information will be stored securely and used only for claim-related purposes.

Signature: _____ **Date:** _____

🔐 *All personal and health information collected will be handled in accordance with privacy legislation and the requirements of the CMTO.*