INSURANCE AND INJURY INFORMATION

Name_____ Birth date_____ Date of injury_____
Address_____ City_____ State_____ Zip_____
Insurance_____ Employer_____ Policy number_____
I.D. number_____ Relationship to insured_____ Marital status_____
Billing address_____ City_____ State_____ Zip_____
Adjusters name_____ Phone number_____
Type of insurance: Employment_____ Auto_____ Other_____
Referring physician_____ Phone number_____
Have you contacted a Lawyer?_____ Name of lawyer_____
Reason for visit, please describe_____

_____

_____

List symptoms post accident (pain, swelling, numbness) and areas of listed symptoms

_____

_____

ASSIGNMENT OF BENEFITS

I am responsible for all charges for all services provided. In the unfortunate even that my insurance company denies payment or makes partial payment, I am responsible for any balance due. If the massage clinic has contracted with my insurance company at a discount rate for services, the amount will be deducted from my bill. I authorize and direct payment of medical benefits to the massage clinic._____
Signature_____ Date_____

RELEASE OF MEDICAL RECORDS

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims.
Signature_____ Date_____

CONTRACT FOR CARE

I will participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based upon the information provided by my massage therapist. I agree to participate in my own self-care program and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well being is compromised.
Signature_____ Date_____