Insurance information

client's full name | date | claim/policy # | date of injury

Is your condition the result of an auto accident? Yes / No If so, in what state did the accident occur?

Was this case related to work auto other explain_____

What type of insurance do you have that may cover you for this condition? (*circle all that apply*)
Auto Workers' compensation/state Industrial Liability Health

Was a police/accident report filed? Yes / No

insured's full name | insured's date of birth

insured's employer | insured's SS #

address | city | state | zip

home phone | cell phone | work phone

employer's name/school name

address | phone

primary insurance plan name | group number | plan number | phone

plan's billing address | city | state | zip

Secondary insurance information

Who is your attending physician? _____

address | city | state | zip

office phone | fax

Permission to consult with _____ regarding _____ Your initials _____

Has an attorney been retained? Yes / No

name | phone

address | city | state | zip

PERSONAL INJURY/AUTO ACCIDENT or SLIP and FALL CASE

- Do you have No-Fault PIP benefits? Yes / No
- Are there benefits left? Yes / No
- Do you have deductible? Yes / No
- Deductible amount? $_____ Has it been met yet? Yes / No
- If not, how much deductible is left to be met yet $_____
- What percentage does your insurance cover _____%
- What are the policy limits $ _____
- Do you have MED-PAY on your policy? Yes / No (picks up the 20%)
- Do you have U/M (Uninsured Motorist Protection)? Yes / No
- Were you cited in the accident? Yes / No / Don't know
- Were you struck from: Behind Front R. Side L. Side
- If other, please explain: _____
- Did you feel pain immediately? Yes / No Where: _____
- If NO, when did you first start feeling pain? _____
- Since the injury are your symptoms: Getting worse Improving Staying the same
- Changing (If changing, please explain): _____
- Were you the: Driver Passenger Pedestrian Other

Information on Driver of Vehicle at Fault:

Name: _____ Phone #: _____

Address: _____ Phone #: _____

Have you obtained an attorney for this case? Yes / No

Attorney or Law Firm Name: _____

Address: _____

Phone: _____ Fax: _____

Client Agreement/Release of Records And Assignment Of Benefits

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Assignment of Benefits

I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance.

I authorize and direct payment of medical benefits to my massage therapist, for services billed.

Release of Medical Records

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

(*Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.*)

Contract for Care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of his or her skills and knowledge.

_____

signature date

_____

signature of parent or legal guardian (if client if a minor)