Valley Massage Therapy

Insurance Information Form

CLIENT & CLAIM

Client _____ **Date** _____ **Insurance ID #** _____

Date of Injury / Accident _____ **Condition** ☐ Auto Accident ☐ Work Injury ☐ Health

If auto accident - State _____ **Police report filed?** Yes No

Relationship to insured Self Spouse Child Other **Other:** _____

Insured's full name _____ **Insured ID #** _____

DOB _____ **Sex** Female Male **Status** Single Married Partnered

Email _____ **Home Phone** _____ **Cell** _____

Mailing Address _____

INSURANCE / CASE

Insurance Company _____ **Adjuster's Name** _____

Adjuster's Phone _____ **Claim #** _____ **Policy / Group #** _____

Billing Address _____

PROVIDERS & ATTORNEY

Primary Care Physician _____ **Phone** _____

Physician Address _____

Other Current Physician _____ **Phone** _____

Permission to contact physicians if medically necessary? Yes No **Attorney retained?** Yes No

Attorney Name _____ **Phone** _____

Attorney Address _____

AUTHORIZATIONS

Assignment of Benefits

I am responsible for all charges for services provided. If my insurance company denies payment or makes a partial payment, I am responsible for any balance due. I authorize and direct payment to my massage therapist, Valley Massage Therapy, Theodore M. Schiff, LMT, for services rendered.

Signature _____ **Date** _____

Release of Medical Records

I authorize release of my medical records or 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 processing my claims.

Signature _____ **Date** _____

Please complete all applicable fields before submitting.