Insurance Information

Patient Name _____ **Date** _____

General Information

Name of insurance company: _____ Insurance ID: _____

Policy holder name: _____ Date of Injury _____

Is this visit related to a new injury or accident? ☐ No ☐ Yes

Auto Related Injury

Have you received any massage in regards to this accident? ☐ No ☐ Yes – if yes, how many? _____

Was the accident your fault? ☐ No ☐ Yes In what state did the accident occur? _____

Primany Insurance Company (your insurance company/insurance of the car you were in)

Name of insurance company: _____ Address _____

Phone number: _____ City _____ State _____ Zip _____

Policy holder name: _____ Policy number: _____ Claim number: _____

Secondary Insurance Company (at fault party's insurance company)

Name of insurance company: _____ Address _____

Phone number: _____ City _____ State _____ Zip _____

Policy holder name: _____ Policy number: _____ Claim number: _____

Attorney Information

Have you spoken with an attorney? ☐ No ☐ Yes Have you retained an attorney? ☐ No ☐ Yes

Attorney name: _____ Address _____

Phone number: _____ City _____ State _____ Zip _____

Job Related Injury

In what state did the accident occur? _____ Is your employer self-insured? ☐ No ☐ Yes

Have you received any massage in regards to this accident? ☐ No ☐ Yes – if yes, how many? _____

Assignment of Benefits My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

Release of Medical Records My signature below authorizes the release of my medical records including intake forms, chart notes, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

Financial Responsibility It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes a partial payment, I am responsible for the balance.

_____ _____

Patient Signature Date

_____

Print name

Instructions:
1) Circle the areas that are bothering you today
2) Write the letter in the circle to describe what you are feeling
3) Rate the feeling on a scale from 1-10 (1: mild, 5: moderate, 10: severe)

P: pain
T: tension/stiffness
N: numbness/tingling
A: ache
B: burning
HA: headache
O: other (explain)