Valley Massage Therapy
Insurance Information Form

Client _____ Date _____ INS ID#_____ DOI_____

Is your condition the result of an auto accident? ___ Yes ___ No ___ Work Injury ___ Health Condition

If so, in what state did the accident occur _____ was a police/accident report filed? ___ Yes ___ No

Client's relationship to insured ___ Self ___ Spouse ___ Child ___ other

Insured's full name: _____Ins. ID#_____

DOB ___/___/___ Female / Male Single / Married / Partnered Email Address:_____

_____

Street / PO Box City State Zip

Phone (H) _____ (W)_____(C)_____

Insurance Co _____ Adjuster Name _____

Phone_____Claim#_____Policy/group#_____

Billing Address _____

Street / PO Box City State Zip

Primary Care Physician _____ Phone _____

Address _____

Other Current Physician _____Phone_____

Do we have permission to contact physicians if medically necessary? ___Yes ___No

Has an Attorney been retained? ___ Yes ___ No

Name _____ Phone _____

Address _____

Street / PO Box City State Zip

Assignment of benefits

I am responsible for all charges for all services provided. In the unfortunate event that 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 Associates, Theodore M. Schiff, LMT for services billed.

_____

Signature Date

Release of Medical Records

I authorize the 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 the purposes of processing my claims.

_____

Signature Date