INITIAL EVALUATION / ASSESSMENT

PATIENT:_____ DATE OF BIRTH:_____ PHONE #:_____

ADDRESS:_____ STATE:_____ ZIP:_____

EMERGENCY CONTACT:_____ EMERGENCY CONTACT PHONE #:_____

EMAIL ADDRESS:_____

INSURANCE:

NAME OF COMPANY:_____

DATE OF INCIDENT:_____

POLICY #_____

CLAIM #:_____

ADJUSTER:_____

PHONE #:_____

EMAIL ADDRESS:_____

ADDRESS:_____

STATE:_____ZIP:_____

DOCTOR:_____

PHONE #:_____

EMAIL ADDRESS:_____

ADDRESS:_____

STATE:_____ZIP:_____

ATTORNEY:_____

PHONE #:_____

EMAIL ADDRESS:_____

ADDRESS:_____

STATE: _____ZIP:_____

HOW WILL PAYMENT BE MADE?

AUTO INSURANCE: ☐ **WORKERS' COMPENSATION:** ☐ **MAJOR MEDICAL:** ☐ **CASH:** ☐ **ATTORNEY LIEN:** ☐

CREDIT CARD: ☐ **CHECK:** ☐ **OTHER:** ☐ **HOW?** _____

CREDIT CARD: TYPE: _____ **CARD #:**_____

EXP. DATE: _____**CV CODE: (3 #'s on back or 4 #'s front of AMEX)** _____

Address used for CC billing: _____**State:**_____ **Zip:**_____

- Was this case related to work? ☐ **AUTO** ☐ **or OTHER** ☐ **Explain:** _____
- How did it happen? _____
- Have you ever been treated for this condition? **YES**☐ **NO**☐
- Has the Insurance company been notified? **YES**☐ **NO**☐
- What makes your condition worse? _____
- Surgery in the past 4 years? **YES**☐ **NO**☐ If yes, explain: _____

_____

LIST 3 MAJOR HEALTH CONCERNS & MEDICATION YOU ARE TAKING: (Use back of form if necessary.)

1._____

2._____

3._____

MEDICATIONS:_____

Do you have any family history such as diseases, preexisting conditions, or possible medical contradictions that might cause concern or that would affect your present injury, illness, or other medical conditions, surgeries, ETC?

YES☐ **NO**☐ If yes, please explain: **USE BACK OF FORM**: _____

I hereby grant permission to the massage therapist(s) at this facility to provide massage services to me. I acknowledge that if I am not satisfied with said care I am free to go elsewhere. I have a right to a copy of my medical records if requested. (I realize that copy charges may apply.) I understand that I am receiving my physician prescribed health care related massage therapy service by a trained, licensed and/or certified massage therapist. I understand that a massage therapist, under no circumstance, is allowed to diagnose or offer a prognosis of my medical condition.

Patients of Legal Representative: _____ **Date:** _____

PERSONAL INJURY / AUTO ACCIDENT OR SLIP & FALL CASE

- Do you have NO - Fault P. I. P. benefits? **YES**☐ **NO**☐
- Are there benefits left? **YES**☐ **NO**☐
- Do you have a deductible? **YES**☐ **NO**☐
- Deductible amount? $_____
- Has it been met yet? **YES**☐ **NO**☐ **If not**, how much 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 struck from: **Behind**☐ **Front**☐ **R. Side**☐ **L. Side**☐ If other, please explain: _____
- Did you feel pain immediately? **YES**☐ **NO**☐ **If yes**, Where? _____
- **If NO**, when did you first start feeling pain? _____
- Were you cited in the accident? **YES**☐ **NO**☐ **DON'T KNOW**☐
- Since the injury are your symptoms: **Getting worse**☐ **Improving**☐ **Staying the same**☐ **Changing**☐ **If changing**, explain _____
- Were you the: **Driver**☐ **Passenger**☐ **Pedestrian**☐ ☐ **Other**_____
- Have you received massage therapy for this condition in the past? **YES**☐ **NO**☐ **if yes, did it help? YES**☐ **NO**☐
- **If you live in a state that is not a no-fault state or do not have MED-PAY on your policy, you must supply the following information.**

INFORMATION ON DRIVER OF VEHICLE AT FAULT:

NAME: _____ **PHONE #:**_____

ADDRESS: _____ **POLICY #:**_____

Have you obtained an attorney for this case? **YES**☐ **NO**☐ **IF YES**, Please fill out our **Attorney Letter of Protection** and provide your attorney's name, phone and fax numbers.

RELEASE OF RECORDS / PAYMENT AGREEMENT / ASSIGNMENT OF BENEFITS

Patient to sign prior to any medical treatment to be preformed

PATIENT: _____ **PHYSICIAN REFFERRAL:** _____ **DATE:** _____

INSURANCE COMPANY: _____ **ATTORNEY (If** applicable**):**_____

I hereby authorize Release of Records to: _____**, my Health Care Provider/Facility to release any and all of my medical information** to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), when necessary for the purposes of my payment of my related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in

Patient's or Legal Representative's Initials: _____

Payment Agreement: All professional services rendered are charged to the patient and the patient is responsible for all fees regardless of Insurance coverage. I acknowledge and understand that all charges for services I receive by my massage therapist(s) are due at the time of service, unless other arrangements have been made in advance. I understand that my insurance coverage is a contract between myself and my insurance carrier and that provider is hereby willing to assist me in collecting those payments from my insurance company for my services. I understand I am responsible to the above -mentioned facility/provider for charges not covered by this assignment, including deductible's and co-payment requirements by my insurance company policy, certificate of coverage or for any unauthorized workers' compensation claims. I further agree legal fees should be required. I understand if my commercial, health or other insurance plan has not paid my medical bill within 60 days of my visit(s), for my services received by my provider/facility, I am responsible, and I will then make whatever arrangements are necessary and available to me to pay all unpaid charges. The payment agreement portion of the instrument may not be revoked in writing or otherwise.

Patient's or Legal Representative's Initials: _____

Assignment of Benefits: This **AGREEMENT** is made and entered into by and between the above named patient and provider. Whereas, Patient desires to receive services from this health care provider and therefore desires to assign certain rights and benefits to PROVIDER it is hereby agreed that I assign to _____, my health care provider/facility, all money to which I am entitled for medically related expenses received at or through the above mentioned facility. The payment shall not exceed my total indebtness for services received through this provider or other providers at this facility. Any payment that facility/health care provider, received by the insurance company, beyond my indebtness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State or Workers; compensation Statutes. Any copy of this document shall be as valid as if it were the original. I, patient or Legal representative have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it.

Patient or Legal Representative's name Printed: _____ **Date:** _____

Patient or Legal Representative's Signature: _____ **Date:** _____

Provider / Facility: _____ **Date:** _____