INSURANCE INFORMATION (for HEALTH INSURANCE CLAIMS)

Client's Full name (as listed on Insurance policy): _____

Date of Birth: _____ Phone #: _____

Address: _____

City: _____ State:_____ Zip: _____

Name of Insurance Company: _____ Insurance Provider Ph.#:_____

Member I.D. #: _____ Group #: _____

Areas of main concern: _____

Name of Primary Care Dr. or Referring Physician: _____

Please fill out the following information if the primary insurer is someone other than yourself:

Primary Insurer's Full name: _____

Date of birth: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Your relation to insured? Spouse Partner Child Other

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. I authorize Low Tide Bodywork to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Low Tide Bodywork. The release of information will remain in effect until terminated by me in writing.

Financial Agreement for Massage Therapy services

Provided by: Low Tide Bodywork. For client:

I agree to pay for these health care services: (*Please initial next to the appropriate box)*

_____ With payments from my **health insurance policy**, plus any co-pay or deductibles that are my responsibility.

_____ With payments from my **Personal Injury Protection** from my car insurance company or with proceeds from a legal settlement if this is in the form of an automobile accident.

Fees rendered at this office are the responsibility of the patient receiving the care or the designated responsible party. Amounts not covered or denied by the insurance company are still the responsibility of the patient.

Signature _____ Date_____

Signature of parent or legal guardian (if client if a minor) Date