INITIAL EVALUATION / ASSESSMENT

PATIENT:_____

DATE OF BIRTH:_____ PHONE #:_____

ADDRESS:_____ STATE:_____

ZIP:_____

EMERGENCY CONTACT:_____

EMERGENCY CONTACT PHONE #:_____

EMAIL ADDRESS:_____

INSURANCE: (Check one) _____ AUTO ACCIDENT CLAIM _____WORKERS COMPENSATION CLAIM

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:_____

RELEASE OF RECORDS / PAYMENT AGREEMENT / ASSIGNMENT OF BENEFITS

PATIENT: _____

PHYSICIAN REFERRAL:_____ REFERRAL 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 deductibles and copayment 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 indebtedness 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 indebtedness 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**: _____