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Confidential Health Intake Form

Name _____Date of Birth _____
Street Address _____
City_____State_____Zip_____
Wk. Phone _____H. Phone _____ Cell Phone_____
Emergency Contact _____
Employer _____Social Security Number _____
Occupation/employer _____
Referring Physician: _____ Primary Care Physician: _____
Was Injury a result of an accident? _____
If yes: Job related_____ Auto _____ Other_____
Date of Injury or onset: _____
Insurance Company Name: _____
Billing Address: _____
Phone Number: _____
Contact person/ case manager _____
Name of Insured: _____Insured's date of birth_____
Address: _____
Phone: _____
Group/Claim Number/Id number: _____
Insured'sss#_____
Attorney (if applicable) Name: _____
Address:_____
Phone number: _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.
I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
I agree to provide 24 hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee. (Please note that insurance companies do not pay this, you do.)

Signature _____ Date _____