

Worker's Injury Insurance Information Form

Patient Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Home # (____) _____ Work # (____) _____ Date of Birth _____
SS# _____ Date of Injury _____ Referring Doctor _____

Please Complete All of the Following:

Claim Number _____ **Adjuster Name** _____
Phone(____) _____ **Insurance Co. Name** _____
(If other than the WA State Dept. of Labor & Ind.) **Address** _____
City _____ **State** _____ **Zip** _____ **Date Claim Opened** _____
Employer _____ **Phone (____)** _____
Attending Physician Name _____ **Address** _____
City _____ **State** _____ **Zip** _____ **Phone (____)** _____
Have you had any Massage Therapy for this injury? No Yes, If Yes # of sessions _____

Please read and sign below:

In fairness to our other patients and to us, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature: _____
(Patient / Parent / Guardian)

Date: _____