Balanced Therapies Massage Insurance Form

balanced therapies massage
HEALTH & WELLNESS CENTER

PERSONAL INFORMATION

Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____

SSN #: _____ DOB: _____ Sex: ☐ M ☐ F

INSURANCE INFORMATION

Insurance Company: _____ Phone: _____

Claims Address: _____

City/State/Zip: _____

Claim #: _____ Policy #: _____

DOI: _____ 1st DOS: _____

PHYSICIAN INFORMATION

Referring Physician: _____ Physician Phone: _____

Physician Address: _____

Diagnosis Code(s): _____ CPT Code: _____

Do you have legal representation pertaining to your workers comp or motor vehicle accident? Y / N

If yes, please provide information:

Attorney Name: _____ Phone: _____

AUTHORIZATION

I authorize the release of any medical or other information necessary to process claims for payment. Balanced Therapies Massage does not suggest or guarantee payment by filing claims on my behalf for insurance purposes. I understand that my insurance is an agreement between the insurance company and myself and I will be accountable for any unpaid balances along with cost accrued due to collections, attorney fees, and/or court costs.

Patient Signature: _____ Date: _____