Essential Body Wellness
THERAPEUTIC MASSAGE

Insurance Information

Personal Information

Patient Name _____ Date _____
Address _____ City/State/Zip _____
Email _____ Date of Birth _____ Occupation _____
Social Security No. _____ Date of Injury _____
Emergency Contact _____ Phone _____
Employer _____

☐ **Auto (PIP)** ☐ **L&I** ☐ **Attorney**

Insurance Company Name _____ Phone _____
Address _____ City/State/Zip _____
ID/Claim No. _____ Group / Plan No. _____
Contact Name _____
Plan / Program Name _____
Referring Physician _____ Phone _____
Attorney _____ Phone _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was created by the US Congress to increase the privacy of individuals' personal health information. It affects all those who are in contact with medical records or personal health information. For a detailed copy of our HIPAA practices please see "Notice of Privacy Practices."

_____ (initial) I have received a copy of the "Notice of Privacy Practices."

_____ (initial) I understand that if I make an appointment and do not cancel that appointment within 24 hours in advance, I will be charged for that missed appointment.

Payment Agreement

_____ (initial) The information I have provided is complete and accurate to the best of my knowledge. I understand that I am responsible for informing Essential Body Wellness – Therapeutic Massage, PLLC (hereinafter Provider) of any changes in my health condition, or any changes in the information as presented on this form.

_____ (initial) I agree to the release of information for medical and/or insurance purposes. I authorize Provider to obtain any information from my primary healthcare providers, my attorney and/or my insurance carrier concerning my health, my insurance claim and any legal proceedings as they relate to my treatment. I authorize the release of any medical or other information necessary to process insurance claims related to treatment to Provider's private medical billing company Puget Sound Medical Billing and Consulting.

_____ (initial) I clearly understand that massage therapy treatments are my personal financial responsibility; if for any reason payment is denied either by my insurance company or by my attorney, I will make arrangements with Provider to pay for all massage treatments I have received.

Patient Signature _____ Date _____