elemental massage therapy

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Confidential Health Information Form – Therapeutic Massage

PLEASE PRINT, Fill out completely & sign.

Last Name ______________________________ Hm Phone ____________________
First Name _________________ M. I. _______ Wk Phone ____________________
Street Address ___________________________ Cell Phone ____________________
City ______________ State ______ Zip _____ Email Address ________________
Occupation/ Activities ___________________ Date of Birth ___/___/___ F☐ M☐
How did you hear about us? ____
Injury Treatment? Yes☐ No☐ Date of Injury ___/___/___ Auto☐ Work☐ Other☐
Name of Referring Physician ______________ Phone ___________ Fax ___________

CO-PAY/PAYMENT IS DUE AT TIME OF SERVICE

YOUR INSURANCE INFORMATION (Complete only if billing Insurance)

I have contacted my **health** insurance company. My massage benefits by a Licensed Massage Therapist are:
_____ - Visits per year or $ per year $ _______ - Deductible $ _______ - Co-insurance $ ______Co-pay
Required proof of medical necessity: ____ RX ____ Referral ___Other ________

CO –PAY DUE AT TIME OF SERVICE

PRIMARY HEALTH INSURANCE: Name of **Primary Insured** (Policy Holder) ______________________
Primary Insured Date of Birth ___/___/___ Relationship to Insured – Self ☐ Spouse☐ Child ☐
Address of Primary Insured ______________________________ State ____ Zip __________

AUTO INSURANCE ______ L & I /WORKER'S COMP _____
Claim # __________________ Claim Adjuster ________________ Phone ________________
Attorney Name ____________________________ Phone __________________

~ PLEASE READ, INITIAL EACH LINE AND SIGN BELOW! ~

_____ I acknowledge that all information provided is complete and accurate. I will notify EMT of any changes to the information presented on this form. Any changes in my physical condition will be told to my treating LMP prior to treatment.

_____ I agree to the release of information to be used for medical and/or insurance billing purposes.

_____ I will not hold EMT responsible to know my health insurance benefits if I have not called for them myself.

_____ It is my responsibility to track my massage in relation to my plan benefits so benefits are not maxed.

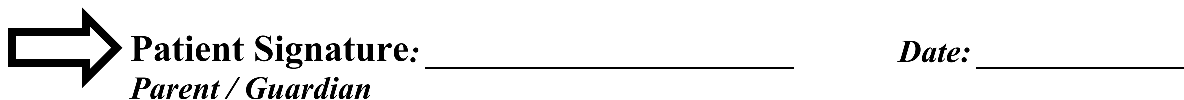
_____ I understand my massage therapist does not diagnose illness or disease, or prescribe any treatments.

_____ I am aware that I am fully responsible for all health care bills for services rendered and that payment is not contingent on any settlement, judgement or insurance payment. An unpaid balance is due 30 days from invoice/statement date. A 1% interest or minimum of $1.00 per month will be charged until the balance due is paid. Rebilling fees may be added. Each returned check will be charged $25.00 plus bank fees. Additional court, attorney or collection agency fees may be charged, up to 50%, if applicable.

_____ I have been given or offered and read the privacy/HIPAA information for Elemental Massage Therapy.

_____ I agree to cancel appointments 24hrs in advance, and call to reschedule ASAP if an emergency arises.

_____ ***Missed or cancelled appointments without 24hr notice, will be charged fee equal to full cash price of the Session.***



Patient Signature: ______________________ ***Date:*** ____________
Parent / Guardian