Hand To Health Therapeutic Massage

Please fill form out legibly and completely to avoid delay in insurance billing.

Patient

Name _____ Male / Female

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ Married Single Other

Insurance Information

Responsible Party _____ Relation to Patient: Self Spouse Child Other

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Age _____ Married Single Other

Who referred you to our office? _____

Insurance Company _____

Insurance Billing Address ***(or copy of front and back of card)*** _____

_____

Insurance Phone Number _____ Contact Person _____

Subscriber ID (or Claim #) _____ Group #: _____

Name & address of any additional person you authorize this office to communicate with regarding your account:

_____

Date of Injury _____ **Work Related?** Yes / No **Auto Accident ?** Yes / No

Diagnosis (provider use only) _____ **Referring Physician** _____

I state that I have insurance as noted above and assign all benefits payable directly to PROVIDER. I understand that my insurance company is billed as a courtesy to me and agree by signing below to pay the charges in full in the event of non-payment by my insurance company within 60 days of billing. I understand that it is my responsibility to meet any referral requirements of my insurance plan and that I will be responsible for payment if claims are denied due to violation of referral policy. I authorize PROVIDER and BILLING SERVICE to release all information necessary (including chart notes) to my insurance company to secure payment of benefits.

Signature _____ **Date** _____

Office Use Only: _____ Pt Info Form _____ Copy of Insurance Card _____ Prescription
_____ Dx Code _____ Referring Dr. _____ Chart Notes if required

730 N. Hamilton, Spokane, WA 99202