Self Balance Massage, INC ~ Medical Massage Intake - MVC

8221 NE Hazel Dell Ave., Suite 103 Vancouver WA 98665 • phone (360) 977-6090 • fax (360) 836-5659

Name: _____ **Date** ____/____/____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Phone: ( ) _____ **E-mail:** _____

Birth Date: ____/____/____ **Occupation:** _____

Employer: _____

Emergency Contact: _____ **Phone:** ( ) _____

Referring Physician: _____

Was injury a result of an accident? yes no

If yes: Job related?_____ **Auto?**_____ **Other?**_____

Date of injury or onset: _____

Insurance Company *(yours)*

Name: _____

Billing Address: _____ **City:** _____ **State** _____ **Zip** _____

Phone: ( ) _____ **Claim Number:** _____

Group or Policy #: _____

Contact Person\Case Manager: _____

Other Parties Insurance *(if applicable)*

Name: _____

Address: _____ **City:** _____ **State** _____ **Zip** _____

Phone: ( ) _____ **E-mail:** _____

Birth Date: ____/____/____ **Employer:** _____

Group or Policy #: _____

_____ **We will assess & collect any additional fees related to collection of delinquent accounts.**
initial

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

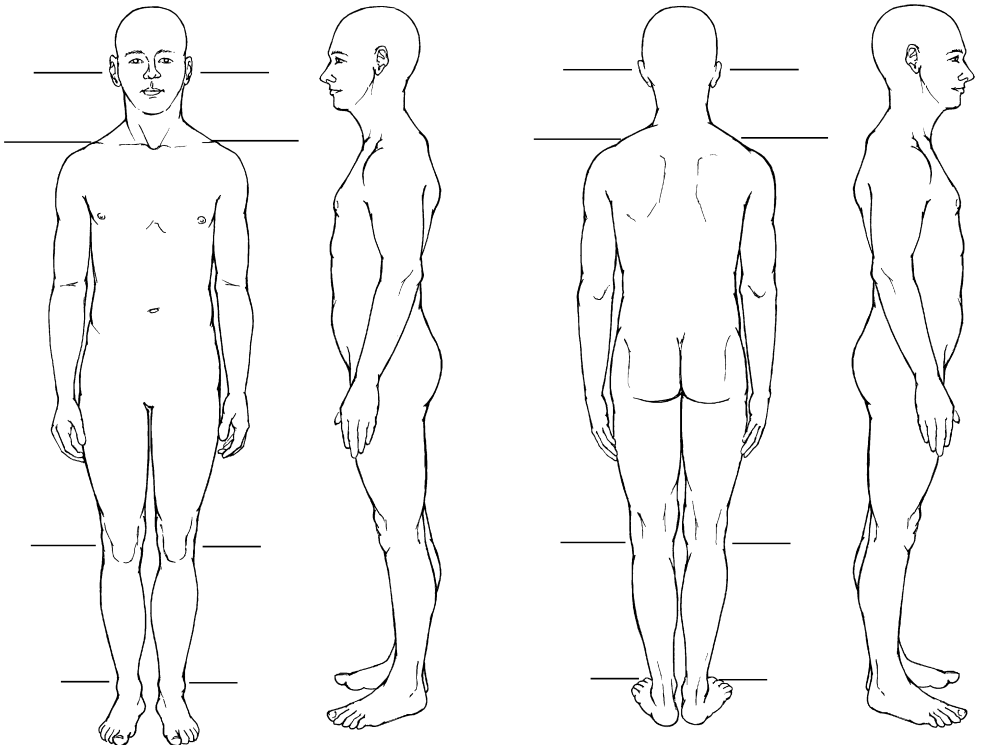
I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

I agree to provide **24-hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee. (Please note that insurance companies **do not** pay this, you do).

Signature: _____ Date: ____/____/____

Signature of parent: _____ Date: ____/____/____

Signed Parent/Guardian Permission if participant is under 18 years of age



Please circle any areas of pain/concern and rate it on a scale of 1-10 (1 low/10 high)

Describe any areas of pain or concern: _____

_____

_____

_____

_____

Office Use: **NOTES**

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