Injury Information

Massage Therapist:_____
Patient Name:_____Date:_____
Date of Injury:_____Claim #_____

1. Was a police report filed?_____
2. Describe Injury:
_____
_____
_____

Describe any cuts, bruises, or abrasions._____

Are your symptoms getting better, worse, or no change?_____
What makes them better and worse?
_____
_____

Did you return to work the next day?
____
Has your work responsibility changed due to injury?_____
Have you ever had this type of injury before?_____
4. Did police arrive at accident?
_____
5. Do you have and airbag and did it activate?_____
6. How was your vehicle hit rear end, head on, or side swipe?_____
7. Were where you seated in vehicle and which way was your head facing?
_____
8. What type of vehicle were you driving? (make, model, year)
_____
_____

9. Was the oncoming vehicle driving or stopping if driving how fast was it going?
_____
_____
10. Were you driving or stopped?
_____

Insurance Information:

Insurance Plan
Name:_____
Address:_____
City_____State_____Zip_____
Phone:_____
Date of Birth_____
Male or Female_____

Before Treatment:

Client must provide:

1. prescription for massage with ICD codes.
2. Car insurance information
3. Claim number
4. Must sign below

Assignment of Benefits
My signature below authorizes and directs payment of medical benefits for services billed to my health care provider:_____

Release of Medical Records
My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims:_____

Financial Responsibility

It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balance:
Signature_____Date_____