Adept Therapeutic Massage

600 1st Avenue, Suite #234 Seattle, WA 98104 (206) 623-0227

Auto Insurance Form

Name:				Today's Date:	
Date of Birth:				Date of Injury:	
Email address:					
Patient Information:					
Address:					
Phone:	(Hm)	(Cell)		(Wk)	
Relationship to insured: Check one	Self ☐	Spouse ☐	Child ☐	Partner ☐	Other ☐
Employer:					
Employer Address:					
Injury is related to: Check one	Employment ☐	Illness ☐	Auto Accident, if so, which state? ☐ State:		Other ☐
Referring Physician:					
Name:		Phone:			
Address:					
Insured (if other than you):					
Name:					
Address:					
Phone:		Date of Birth:			
Insurance Information:					
Insurance Carrier:					
Insurance ID:					
Claim #:					
Adjustor:		Phone Number:			

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 am fully responsible for the balance. I also agree to give a 24-hour notice in the event of a cancellation. If I do not provide Adept Therapeutic Massage with a proper notice, I am responsible for paying for my allotted time at the current hourly rate. I understand that my insurance company is not responsible for paying missed appointments. ___(initial)

Release of Medical Records

I authorize Adept Therapeutic Massage to release my medical records including intake forms, chart notes, reports and billing statements to my attorneys, health care providers and insurance companies. I will inform Adept Therapeutic Massage if I sign any exclusive Release of Medical Records with my attorney.

Signature: _____ Date: _____