Motor Vehicle Collision Confidential Client Information

Name: _____ Date of Birth: _____
First M.I. Last MM/DD/YYYY

Address: _____
Street City State Zip

Phone Number: _____ E-mail: _____

Primary Care Physician: _____
Name Clinic Name and Phone #

Auto Insurance : _____
Company Name Policy #

Claim#: _____ Date of Incident: _____

Claim Adjustor: _____
Name Phone # Fax #

Primary Insured: _____
Name Street Address City, State, Zip

Primary Insured's DOB: _____ Relationship to Primary Insured: _____

Health Insurance: _____
Company Name Policy ID #

Emergency Contact: _____
Name Phone # Relationship

Attorney (if applicable): _____
Name Office Name Phone #

Referring Medical Provider: _____
Name Clinic Name

Phone Number: _____ Permission to consult (circle one): Yes No

Brief Description of Incident and Resulting Injuries:

_____

_____

_____

_____

Are you currently taking any medications? Please list: _____

_____

What are your primary goals for your massage treatment(s)?

_____

Barrie L. Robbins,
LMT #17639, CTP
tragermoves.com
541-241-2087

Client Agreement:

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for therapeutic massage treatment. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. *Initial* ____

In consideration of my fellow patients and massage practitioner, I understand that a minimum of 24 hours notice is required to change or cancel an appointment. I further acknowledge that I will be held responsible for the full cost of the session should I cancel, miss, or reschedule within the 24 hour time period, unless I send someone in my place. I understand my insurance company *will not pay* for the missed appointment. *Initial* ____

Release of Medical Records:

I authorize the release of medical records or other health information, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, healthcare providers, and insurance case managers, for purpose of processing my claims. *Initial* ____

Assignment of Benefits:

I am responsible for all charges for all services provided. In the event that my insurance company denies payment, or makes partial payment, I am responsible for any balances due. I authorize and direct payments of medical benefits to Barrie Robbins Bodywork. *Initial* ____

By my signature, I verify that all information provided is true and correct to the best of my knowledge. Furthermore, I agree to abide by these policies.

Signature: _____ Date: _____

Barrie L. Robbins,
LMT #17639, CTP
tragermoves.com
541-241-2087