Eagle River Therapeutic Massage

Insurance Registration Form

Personal Data:

Name of Client: ____ Date: ________________
Date of Birth: _________________ Gender: M_____ F_____ Soc Sec #:________________________
Address: ____________________________________ City, State, Zip: _________________________
Home Phone: ___________________ Work #:____________________ Cell #:___________________
Email: ____

How did you hear about us? ____

Person responsible for payment: Client___ (skip to next section) Other ___ (fill out their info below)
Name: _________________________________ Relationship to client: ________________________
Date of Birth: _________________ Gender: M____ F____ Soc Sec #:__________________________
Address (if different than Client):______________________City, State, Zip: _____________________
Home Phone: ___________________ Work #:___________________ Cell #:___________________
Email: ____

General Insurance Questions:

Are you a college student still covered by your parent(s) insurance? Y___N___
Full Time___ Part Time___
Are you seeing us for a worker's compensation claim? .... Y___N___
Are you seeing us for injuries related to an automobile accident? ......Y___N___
Date of Injury: _______________ Body part injured:______________________________________

Worker's Comp insurance information (fill out only if you are seeing us under worker's comp):

Name of insurance company: ___________________________ Phone#:______________________
Address: _________________________________ City, State, Zip: ___________________________
Name of employer: ____
Employer Phone #:__________________ Contact Person's Name: __________________________
Worker's Comp Claim #:____
Case Adjustor's Name & Ph #:____

Automobile insurance information (fill out only if you are seeing us for an automobile accident):

Your automobile insurance company:_________________________ Phone#:___________________
Address: _________________________________ City, State, Zip: ___________________________
Your agent's name: _______________________________________ Phone #:__________________
Claim #:____________________________ Police Report #:_________________________________

Other Party's Name: ____
Their automobile insurance company:_________________________ Phone #:__________________
Address: ________________________________ City, State, Zip: ____________________________
Their agent's name: _______________________________________ Phone #:__________________

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Medical Insurance Information:

Primary Medical Insurance Company:____
If insurance is through employer, name of employer: ____
If you do not have the insurance card:
ID#:________________________ Plan Name: ____
Group #:_______________________ Group Name: ____

Policyholder info (if different than Client):
Name: _____________________________________ Relationship to Client: ________________________
Date of Birth: ___________________ Gender: M____ F____
Address (if different than Client):________________________City, State, Zip: ______________________
Home Phone: _____________________ Work #:_____________________ Cell #:____________________
May we contact this person if we have questions about this insurance? Y___ N___

Secondary Medical Insurance Company: ____
If insurance is through employer, name of employer: ____
______ (initial) I understand that I still have to pay Eagle River Therapeutic Massage the deductible for my primary insurance before my secondary insurance will pay.
If you do not have the insurance card:
ID#:________________________ Plan Name: ____
Group #:_______________________ Group Name: ____

Policyholder info (if different than Client):
Name: ____________________________________ Relationship to Client:__________________________
Date of Birth: ___________________ Gender: M____ F____
Address (if different than Client):________________________City, State, Zip: ______________________
Home Phone: _____________________ Work #:_____________________ Cell #:____________________
May we contact this person if we have questions about this insurance? Y___ N___

Patient Agreement and Authorization:

I agree to pay my deductible, coinsurance, and/or copay at the time of service. I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of my government and/or private insurance benefits directly to Eagle River Therapeutic Massage. I understand that Eagle River Therapeutic Massage files insurance for me as a courtesy, and I agree to pay all charges my insurance does not pay or that Eagle River Therapeutic Massage cannot collect from my insurance in a reasonable amount of time with a reasonable amount of effort.

Signature of person responsible for paying for visits:____

Please attach copies of all insurance cards