

CLIENT AND INSURANCE INFORMATION FORM

Client is to complete BOTH SIDES of this form

CLIENT INFORMATION

Client's Name: (Last, First, MI) _____

Social Security # _____ Street Address _____

City: _____ State: _____ ZIP: _____

Date of Birth (Month, Day, Year) _____ Age _____ Male or Female (M or F) _____

Marital Status (Single, Married, or Other) _____ Telephone (Area Code First) _____

Is the Client employed? _____ Is the Client a Student? (Full time, Part time, or No) _____

Employer or School Name _____

INSURANCE INFORMATION

How is the Client related to the Policy Holder? (Self, Spouse, Child, Other) _____

Policy Holder's Name (Last, First, MI) _____

Street Address _____ Telephone # _____

City: _____ State: _____ ZIP: _____

Date of Birth (Month, Day, Year) _____ Age _____ Male or Female (M or F) _____

Employer or School Name _____

Insurance Type (Health, Worker's Comp., Auto) _____

Insured person's ID Number _____

Insurance Plan or Program Name _____ Policy Group Number _____

Claim Number _____ (Claim Numbers are normally required for Auto Insurance)

Claim Representative's Name _____ Telephone # _____

Claims Office Address: (Number and Street) _____

City: _____ State: _____ ZIP: _____

(NEXT PAGE PLEASE)

Is the client covered by a policy other than above? _____ (If not, skip the next 4 lines)

Name of the Person Who Holds the Other Policy (Last, First, MI) _____

Male or Female (M or F) _____ Date of Birth (Month, Day, Year) _____ Age _____

Other Policy or Group # _____ Other Insurance Plan Name _____

Employer or School Name for the Person Who Holds the Policy _____

MEDICAL INFORMATION

Client's Name: (Last, First, MI) _____

Date of Current Condition (Month, Day, Year) _____
(Enter the date the client sustained the injury, or was diagnosed with the illness)

Name of Practitioner who Prescribed Massage Therapy (Last, First, MI) _____
(Enter the name of the doctor or chiropractor as it appears on the prescription)

In the space, below please enter the diagnosis codes provided by the practitioner above:

_____._____._____

Is the client's condition related to Employment? _____ To an Auto Accident? _____

Other Accident? _____ If the condition is accident-related, where did the accident occur? (State) _____

If an accidental injury, is an attorney involved? _____ (If not, skip the next 3 lines)

Attorney's Name _____ Name of Practice _____

Street Address _____ Telephone # _____

City: _____ State: _____ ZIP: _____

HEATH INSURANCE COVEREGE CHECKLIST

Name of your insurance representative _____ Phone _____ Date _____

Is it a requirement that the massage therapist belong to a particular organization? (HMO, PPO, etc.) _____

Amount of Deductible \$ _____ Per individual _____ or family _____ Any pre-existing condition clauses? _____

Has the deductible been met? _____ After the deductible has been met, the policy pays _____% per treatment.

Maximum number of massage therapy visits allowed per year _____

Maximum to be paid for massage therapy \$ _____

Number of massage therapy visits already obtained this year _____

Amount paid for massage therapy this year \$ _____