Patient Insurance & Information Release

Patient Name: ____
Last First MI

Claim#: ____________________ Date of Illness/Injury: ____________________

Patient's Condition Related To: (circle one) Employment Auto Accident (State:____) Other Accident

Referring Physician: ____________________ Physician Phone: ( ) ____________

Diagnosis Codes: ____

PATIENT INFORMATION:

Patient Address: ____
Street Apt #

____
City State Zip Code

Patient Phone: ( ) ____________ ( ) ____________ ( ) ____________
home work other

Date of Birth: ____________ Sex: F M SSN: ____________

Patient Status: Marital Status: S M Other Employed FT Student PT Student

Patient or Authorized Signature: ____________________ **Date:** ____________

I authorize the release of any medical or other information necessary to process this claim.

INSURED INFORMATION:

Insured Name: ____
Last First MI

Employer Name: ____

Patient Relationship to Insured: (circle one) Self Spouse Child Other

Insured Address: ____
Street Apt #

____
City State Zip Code

Insured Phone: ( ) ____________ ( ) ____________ ( ) ____________
home work other

Date of Birth: ____________ Sex: F M SSN: ____________

Insurance Plan Name: ____

Insurance Phone: ( ) ____________ Policy/Group#: ____________

Insured or Authorized Signature: ____________________ **Date:** ____________

I authorize payment of medical benefits directly to the provider below* for massage therapy services rendered to the above patient.

BENEFIT VERIFICATION – to be completed by BodyWorks

Contact Name: ____

Claims Address: ____
Street or P.O Box Suite #

____
City State Zip Code

Attention: ____

CPT Codes verified: Insured's ID: SSN or claim#

Med Pay verified: Funds available: yes no

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*Benefits to be paid directly to:

BodyWorks Therapeutic Massage LLC
4340 E. Kentucky Ave., Suite 446
Glendale, CO 80246