spirit moves BODYWORK

New Client Intake Form

Please complete both front and back.

Glendy Morrison, LMP

Client information				
Last name of client:	First name:	MI:	□ Male □ Female	Age:
Address:	City:	State:	Zip code:	
Home Phone:	Cell Phone:	Date of birth:	Social security No:	□ Married □ Single
Employer:	Work Address and Phone #:			

Responsible party information (If different then above)				
Last name:	First name:	MI:	□ Male □ Female	Age:
Address:	City:	State:	Zip code:	
Home Phone	Cell Phone:	Date of birth:	Social security No:	Relationship to client:

Medical Insurance Information			
Primary Insurance company Name:	ID#	Group#	
Address:	City:	State:	Zip code:
Phone:	Name and address of insured (if different then client):		
Relationship to insured: Self Husband Wife Child Other (explain):			

Information for massage therapist
Reason for today's visit:
How did you hear about Glendy?:

Payment of Benefits

I understand that Glendy's Massage Therapy will bill my insurance if I have provided adequate information (ID and insurance card). I authorize payment of benefits by my insurance company directly to Glendy's Massage Therapy. I agree that after 60 days all balances due become my responsibility regardless of insurance coverage. I also agree that all charges not paid by my insurance company will be my responsibility.

Terms

If no insurance coverage, full payment is required at time of service

There will be a rebilling fee on any balance 30 days. The rebilling fee is 1% or minimum of $3.00 per month. There will be a charge of $35.00 on any checks returned by your bank.

No show policy

A $25.00 "No Show" fee will be charged for failing to show up on time for a scheduled appointment without canceling at least 24 hours in advanced. Additionally, future appointments cannot be scheduled until the "No-Show" fee is paid. "No-Show" fees are not covered by L&I, PIP, or health Insurance.

Medical Release Authorization

Insured party or dependent patient, if not a minor, must sign for all claims.

I authorize any insurance company, organization, employer, hospital, or health care provider to release any information requested with regard to processing my claim.

I certify that the information I furnish is true and correct.

I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

I authorize my massage therapist to speak and confer with all health care practitioners involved in my case/claim.

~ Please continue on the back ~

Medical Information

☐ first massage	☐ heart ailment	☐ headaches	☐ contact lenses
☐ high blood pressure	☐ neck/spine injury	☐ on daily medication	☐ high cholesterol
☐ osteoporosis	☐ cold/flu virus	☐ diabetes	☐ sciatica
☐ pregnancy	☐ phlebitis	☐ scoliosis	☐ AIDS
☐ varicose veins	☐ acute/chronic pain	☐ arthritis	☐ asthma/allergies
☐ sports injury	☐ ulcerated colon	☐ kidney aliment	☐ tendinitis
☐ SLE	☐ cancer	☐ skin disorder	☐ carpal tunnel
☐ tinnitis/ringing in ears	☐ numbness/tingling	☐ dizziness	☐ rash/warts

☐ regular exercise/sports activity_____

☐ other_____

List any allergies you have (include food and medication)._____

_____

List any surgeries, hospitalizations, or major injuries you have. Include date._____

_____

_____

_____

List any chronic medical conditions you presently have._____

_____

_____

List any medications you are currently taking._____

_____

L&I and PIP information

Insurance company Name:	Name of Policy holder:	Date of injury: _____/_____/_____	
Group#:	Claim#:	Member ID#:	
Billing Address:	City:	State:	Zip code:
Claim Adjusters name:	Claim Adjusters phone #: ( )	Do you have a prescription: ☐ Yes ☐ No	

SIGNATURE:_____ DATE:_____/_____/_____