



**PRIVATE INSURANCE INFORMATION FORM**  
*The requested information below is required to bill your insurance*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home#: \_\_\_\_\_ Cell#: \_\_\_\_\_ Work#: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Referring HCP: \_\_\_\_\_

Insurance is: (circle one) **Health** / **Labor & Industries** / **Automobile PIP** (your car insurance)

Insurance Company Name: \_\_\_\_\_

Adjuster's Name(auto): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Claim#: \_\_\_\_\_

**\*\* Credit Card Number:** \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Name on your card: \_\_\_\_\_

**We require a copy of your credit card on file at the time of your treatment.**

*\*\* We will be glad to bill your insurance for you as long as we have "security of payment". You may choose to pay for each treatment at the time of service OR you can provide your credit card information above and we will bill your insurance plan for you. WE WILL NOT BILL YOUR CARD UNLESS we learn that massage is not a covered benefit by your insurance coverage, if you are satisfying a deductible, or we do not receive payment within 45 days of billed treatment. If we actually were to charge your card for treatment and later received payment from your insurance company, we would immediately refund the insurance reimbursement to your card.*

In fairness to all of our patients, 24 hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, we will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment and insuring that any referral, prescription or additional information required by your insurance company is complete and current. Patient agrees to pay all collection costs including, but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above Insurance company for the express purpose of payment for my medical bills incurred in this office.

I hereby authorize the Insurance company or attorney to remit payment directly to this office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_