The Healing Garden
mend the body, nurture the soul

Accident Claim Information

Today's Date:_____

Client Name: _____ Date of Birth _____

Address_____

_____

Phone_____

Name of Insured_____

Address of Insured (if different from above)_____

_____

Claim Number_____ Date of Injury _____

Insurance Company_____

Policy Number_____

Address_____

_____

Claims Adjustor:_____ Phone_____

Do you have a doctor's prescription? YES / NO

Referring Physician_____ Phone_____

*To aid in the timely submission of the claim, we ask that you please request the referring physician to provide you with a prescription that includes **ICD-10 Diagnosis Codes.** In order for us to bill your insurance, every question on this page must be filled out. Thank you!*

Personal Injury Consultation

Name_____ Today's Date _____

Date of Injury _____ Were you the: Driver ( ) Passenger ( )

Were you wearing a seatbelt? YES / NO Were airbags deployed? YES / NO

How fast were you traveling at time of impact?_____

Were you transported to a hospital? YES / NO

Were you seen by a doctor? YES / NO How soon after accident?_____

Do you have a doctor's prescription for massage with you today? YES / NO

(This is required for us to bill your insurance)

Please describe auto accident_____

_____

_____

_____

_____

_____

Please describe your injuries_____

_____

_____

_____

_____

How do you feel today?

_____

_____

Release of Information Authorization

Client Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

E-mail: _____

Date of Birth: _____

I authorize The Healing Garden Massage Therapy to release all medical records or other Protected Health Information (PHI), including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment as requested by my health insurance carrier or any other third-party payers.

I authorize The Healing Garden Massage Therapy to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to The Healing Garden Massage Therapy.

I also authorize the release of my medical records or other PHI concerning my health and treatment during the duration of my care to be sent to the following person or company:

Company: _____

Name: _____

Address:

_____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

I agree that these provisions will remain in effect until I provide written revocation to The Healing Garden Massage Therapy.

_____

Signature of Client or Authorized Representative **Date**