# PATIENT & INSURANCE DATA

**INFORMATION NEEDED FOR COMPLETING HCFA-1500 CLAIM FORMS**

**MASSAGE THERAPIST:**

_____

## PATIENT INFORMATION

NAME:_____

ADDRESS:_____

CITY:_____ST:____ZIP: _____

PHONE: H_____W_____

SS#:_____-_____-_____

DATE OF BIRTH:_____AGE_____

**CURRENT EMPLOYER:**

_____

ADDRESS:_____

PHONE: _____

**WORK COMP CASES: EMPLOYER AT TIME OF INJURY:**_____

ADDRESS:_____

CITY_____PHONE_____

| |
|---|
| **SEX**: MALE : □ FEMALE: □ ( **CHECK BOX** ) |
| **STATUS:** SINGLE: □ MARRIED: □ SEPARATED: □ DIVORCED: □ WIDOWED: □ OTHER: □ |
| **EMPLOYED:** FULL TIME: □ **PART TIME:** □ RETIRED: □ UNKNOWN: □ NON-EMPLOYED: □ |
| **F/T STUDENT:** □ **P/T STUDENT:** □ |
| **CONDITION IS RELATED TO:** EMPLOYMENT: □ AUTO ACCIDENT: □ OTHER: □ |
| **STATE OF OCCURANCE**: |
| GRADUAL: □ **FIRST DR. APPT**: |
| OR INJURY: □ **DATE OF INJURY:** |

ANY DATES UNABLE TO WORK?
FROM_____/_____/_____ TO_____/_____/_____

EMERGENCY ROOM VISIT? DATE_____/_____/_____

HOSPITALIZATION?
FROM_____/_____/_____ TO_____/_____/_____

**PRESCRIBING PHYSICIAN:(**incl.credentials,eg "MD")

_____

PHYSICIAN ID #:_____

**# OF VISITS PRESCRIBED BY DR.:**_____

DIAGNOSES_____

_____

## INSURANCE INFORMATION

PATIENT'S RELATION TO INSURED:
___SELF SPOUSE CHILD OTHER

**NAME OF INSURED (if different than patient)**

_____

SS # :_____-_____-_____DOB / /

ADDRESS:_____

CITY:_____ST: ZIP:_____

**INSURANCE CO**:_____

PLAN NAME:_____
**CLAIMS OFFICE ADDRESS**:_____

CITY:_____STATE: ZIP: _____

CLAIM OR CASE #: _____

INSURED'S ID #:_____

POLICY/GROUP #:_____

ADJUSTER:_____

PHONE:_____

# OF VISITS AUTHORIZED BY INS:_____

| **PAYMENT WILL BE EXPECTED AT EACH VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN** |
|---|
| **PLEASE CHECK ONE:** CASH:_____ CHECK:_____CREDIT CARD: _____ OTHER |
| CREDIT CARD TYPE: _____ CARD #: _____ EXP. DATE: |
| AUTO INS:_____ATTORNEY LIEN:_____ WORKERS' COMP. INS:_____ MAJOR MED: |

**IF CASE IN LITIGATION, ATTORNEY:** _____

ADDRESS:_____

CITY:_____ST:_____ZIP: _____

PHONE: _____

**IN AN EMERGENCY CONTACT**_____
**PHONE**

# Colorado Advanced Massage

Notice of privacy practices

In accordance with The Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding this **center's use of your Protected Health Information. This notice also** describes how your health information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by Colorado Advanced Massage.

Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us and we will disclose health information about you to that doctor. For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your medical massage therapist needs to know about, while your medical massage therapist will share all findings with the prescribing doctor.

We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about treatment you are going to receive to determine whether your plan will cover it.

Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for medical massage.

Although your health record is the physical property of Colorado Advanced Massage, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions and medical and billing records.

If you believe that health information we have about you is incorrect or incomplete, you may request in writing that we amend your health information for as long as this office keeps the information.

Our disclosure of your health information is limited to: this office, the physician who prescribed physical medicine, your insurance company, your attorney, and you. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient, and the patient's health information will be disclosed to the parents or guardian.

If you believe your privacy rights have been violated, you may file a written complain to the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Room 509 F, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.

By signing this form, you hereby acknowledge that Colorado Advanced Massage may release your Protected Health Information to carry out payment and treatment operations.

I have read and understand the Notice of Privacy Practices of Colorado Advanced Massage.

_____Date_____

Patient/Patient Representative Signature

# HEALTH HISTORY

ANSWER THE FOLLOWING QUESTIONS BRIEFLY:

Areas of pain or discomfort:

_____

How did it happen? _____

_____

If it happened at work, was the employer notified? Yes No

Has the insurance company been notified? Yes No

Are you currently employed? Yes No

If your accident was work-related,
are you currently employed by the same employer? Yes _____ No _____

Are you presently under a doctor's care? Yes _____ No _____

Have you ever been treated for the same condition? Yes _____ No _____

Were you admitted to the hospital? Yes _____ No _____

Date of admittance: _____ Date of release: _____

What makes your condition worse? _____

Any surgery in the past 4 years? Yes _____ No _____

If yes, explain: _____

Do you: Smoke? Yes _____ No _____ Use Alcohol? Yes _____ No _____

Tea or caffeine? Yes _____ No _____ Chocolate? Yes _____ No _____

If female, are you pregnant? Yes _____ No _____

Do you have High Blood Pressure? Yes _____ No _____

Heart Condition? Yes _____ No _____

Varicose Veins? Yes _____ No _____

Do you have any form of cancer? Yes _____ No _____

If yes, where in the body? _____

Any other condition that might be aggravated by Massage Therapy?
Yes _____ No _____

If yes, explain: _____

List three (3) major health complaints:

#1: _____

#2: _____

#3: _____

List any medications you are currently taking:

_____

List other pertinent information you think might be useful. If necessary, continue on back.

_____

_____

_____

# AUTO INJURY QUESTIONNAIRE

Do you have No-Fault P.I.P. benefits or Med-Pay? Yes_____No_____

Are there benefits left? Yes_____No_____

Do you have a deductible? Yes No _____

How much is your deductible?_____Has it been met? Yes No _____

If not, how much deductible is left? $_____

After your deductible is met, what percentage does your insurance cover?_____%

What are the policy limits? _____

Do you have U/M (Uninsured Motorist Protection)? Yes_____No_____

Were you cited in the accident? Yes_____No_____Don't know_____

Were you struck from? Behind_____Front_____R. Side__L. Side _____

If other, please explain: _____

Did you feel pain immediately? Yes_____No_____

If NO, when did you first start feeling pain:

_____

Since the injury are your symptoms:
Worse___Improving___Changing___Unchanged___

If changing, please explain:

_____

Were you the: Driver? _____ Passenger? _____ Pedestrian? _____

## INFORMATION ON DRIVER OF VEHICLE AT FAULT:

Name:_____Phone: _____

Address:_____Policy No.: _____

Comments:_____

Have you retained an attorney for this case? Yes No _____

**ASSIGNMENT OF BENEFITS/RELEASE OF RECORDS/**
**LIMITED POWER OF ATTORNEY/PAYMENT AGREEMENT**

**ASSIGNMENT OF BENEFITS:** **Patient Initial Here: _____**

To Insurance Company:_____I hereby direct and instruct you to make payment directly to the undersigned provider (s) for medical claims submitted by them on my behalf for medically necessary treatment. This shall also serve as a "Limited Power of Attorney". Please provide them with any and all information regarding my policy benefits and coverages. Your denial or delay to do so in a timely manner will be considered just cause for myself or provider to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider to file this complaint on my behalf if deemed necessary.

**RELEASE OF RECORDS per signed HIPAA Privacy Stmt: Patient Initial Here: _____**

To Provider of Services:_____I have read and understand your Privacy Practices under HIPAA, and I hereby authorize you to release to any attorney, physician, or insurance company, involved in my case, any medical or other records or information necessary to process my claim. I understand these records may be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained on (date) / / .

**PAYMENT AGREEMENT:** **Patient Initial Here: _____**

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including unpaid deductible and/or unpaid percentage amounts due to you according to my policy coverage, in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf.

I understand that 12 hours notice is required for cancellation of appointments, and I will be charged for missed appointments without proper notice at 50% of the normal rate.

I understand I may elect to be billed monthly or at the time of each visit for the balances due to you from each visit. I elect to pay by Check Cash Credit Card___

**NOTE: It is illegal to bill the patient for any balance if W/C is paying the claim**.

SELECT AND INITIAL ONE

1. I elect to pay the unpaid balances at the time of each visit _____

2. I elect to be billed for the balance at the end of each month _____

3. I elect to have outstanding bills sent to my attorney to be paid at the time of settlement if there is a settlement; if either no settlement or payment occurs, then I understand and agree that I will be responsible for payment to you for services provided by your facility _____

**PATIENTS' NAME** _____

**ADDRESS:**_____

**PATIENTS' SIGNATURE:**_____**DATE: / /___**

**PROVIDERS' SIGNATURE:**_____**DATE: / /___**

# Credit Card Authorization

I,_____, a patient seeking health care, have assigned insurance benefits to_____, a health care provider, for services rendered to me by him/her. In addition to assigning payments to said health care provider, I have signed a financial agreement with said health care provider stating that I shall be fully responsible for any payments due to said health care provider that are denied by my insurance company. In the event that my insurance company does not pay for services provided to me by said health care provider, and I do not make reasonable and consistent payments, I hereby authorize_____, said health care provider, to charge all past due payments to my credit card or debit card listed below.

Credit/Debit card company_____

Name of cardholder as it appears on the credit card_____

Credit card number_____Expiration date_____