

MEDICAL MASSAGE INTAKE FORM

Patient Name: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

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

Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Telephone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Insurance Company Name: _____
Address: _____
Adjuster: _____ Phone: _____
Claim/Policy #: _____ Date of Incident: _____
Name of Insured: _____ DOB _____

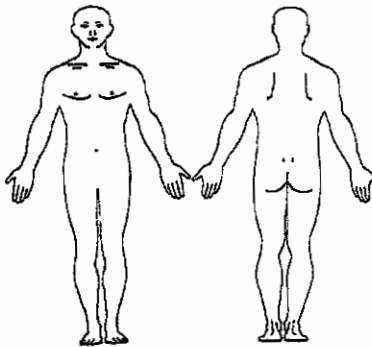
Doctor: _____
Address: _____
City: _____
State: _____ Zip: _____
Telephone #: _____

Attorney: _____
Address: _____
City: _____
State: _____ Zip: _____
Telephone #: _____

Notify/Emergency Contact: _____
Relationship: _____ Telephone #: _____

MEDICAL MASSAGE INTAKE FORM 2

- Is this case related to: Auto\_\_\_ Work\_\_\_ Other\_\_\_ Explain:\_\_\_\_\_
- Has the insurance company been notified? 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\_\_\_\_\_ How long?\_\_\_\_\_
- Please indicate with an X the places you are feeling discomfort:



- What makes your condition worse? \_\_\_\_\_
- Please list all medications you are taking: \_\_\_\_\_

- Do you have a history of the following?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Accident      | <input type="checkbox"/> Varicose veins      | <input type="checkbox"/> Decreased range of motion  |
| <input type="checkbox"/> Neck pain     | <input type="checkbox"/> Surgery             | <input type="checkbox"/> Broken bones               |
| <input type="checkbox"/> Whiplash      | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Fibromyalgia               |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> Disc problems | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Taking blood thinners      |
| <input type="checkbox"/> Mid-back pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nervous tension            |
| <input type="checkbox"/> Low-back pain | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Allergies to perfumes/oils |

- Have you ever received massage therapy? Yes\_\_\_\_\_ No\_\_\_\_\_



## MEDICAL RECORDS RELEASE FORM

To Provider of Services:

*Heaven & Health, LLC*

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. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/ illness sustained on:

\_\_\_\_/\_\_\_\_/\_\_\_\_.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

To Insurance Company: \_\_\_\_\_

Provider of Services: *Heaven & Health, LLC*

I hereby request that you pay directly to this above -mentioned provider of services, any moneys that are due and owing on my case, for services rendered by them to me. This assignment can be submitted by fax or copies and shall be as valid as if it were the original. This assignment may in the future, be revoked by my attorney.

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_.

## ATTORNEY LETTER OF PROTECTION

Notice to Attorney: \_\_\_\_\_

Reference: Your Client /Our Patient: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Claim Number: \_\_\_\_\_

I / My Facility has rendered or is rendering medical services to the above -mentioned patient. Our Patient/Your Client has authorized, and directs, by his/her signature below, that you, as the attorney on this case, protect our outstanding bill for services arising out of this accident by withholding such sums from any settlement, judgment, verdict or other sources, that may become available to protect Me/My Facility's outstanding bills, by making direct payment for our bills, to Me/My Facility, when, and should a settlement occur

We understand that this is providing the settlement is adequate to cover all or an equal percentage, of our outstanding medical bills, and all other protected bills and legal fees Patient/Client and I understand that, should not enough arise out of the settlement, or should you not be able to obtain a settlement for whatever reason, Patient/Client shall be solely responsible for all outstanding balances with Me/My Facility.

**I / My Facility realizes that as long as litigation is in process for this accident, and as long as this Patient/Client remains a Client with You/Your Firm, we will not initiate any collection proceedings for any unpaid balances until the case has been resolved. I understand to do so, would void this Letter of Protection. Patient hereby agrees that should for any reason, your services, or that of your firm, be suspended, I/My Facility may then begin collection proceedings immediately, unless patient obtains a letter of protection from another law firm immediately.**

I / My Facility will cooperate with you in any manner possible, including making available to you, upon request, copies of any and all bills, and documentation reflecting treatment on this Patient / Client for which payment is expected out of this settlement

I / My Facility, the undersigned Patient / Client, and Attorney, hereby agrees to observe all of the above terms and conditions

**Patient/Client:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Patient's Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Patient/Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Attorney/Firm:** \_\_\_\_\_

**Attorney Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Firm Address: City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Lic#:** \_\_\_\_\_

**Therapist Address:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_ **DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_