

MEDICAL MESSAGE 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 _____

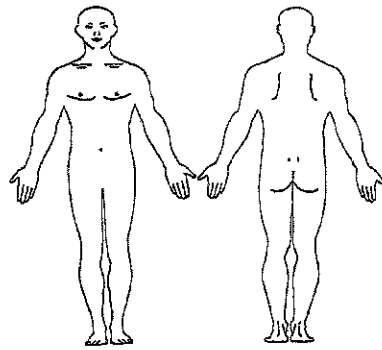
Doctor: _____	
Address: _____	
City: _____	
State: _____	Zip: _____
Telephone #: _____	

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 _____

WORKERS' COMPENSATION FORM

WORK RELATED INJURY INFORMATION

- ◆ Has injury been reported to immediate supervisor or foreman? Yes NO
- ◆ If yes, Give his or her name: _____
- ◆ May I call your employer for authorization to treat you? Yes: NO
- ◆ Have you retained a Workers' Comp. attorney for this case? Yes: NO
- ◆ Date and time this injury occurred: Date _____ Time _____
- ◆ Area that you felt pain immediately after the accident _____
- ◆ Did you return to work? Yes NO Same Company? Yes: NO
- ◆ If not currently working give last date of employment: _____
- ◆ Have you ever injured this area before? Yes: NO
- ◆ Did you lose time from work at that time? Yes: NO
- ◆ Do any other medical problems affect your employment? Yes: NO
- ◆ During daily work or activities, do you have to favor any part of your body? Yes NO
- ◆ Explain: _____

- ◆ Have you ever had a Workers' Compensation claim before? Yes: NO
- ◆ Since the injury, symptoms are: Improving? Worse? Same? Changing?
- ◆ Please Explain: _____

WORKERS' COMPENSATION FORM

◆ Explain in detail how your accident happened? _____

◆ Any Other Comments about your injury or treatment you have received that you wish to add:

Patient Please Read & Sign Below:

"I understand that once I am an authorized Workers' Compensation Patient, I am not to be billed, by you, your staff, or facility, for services, under any circumstances. The only exception is, unless I am required by law to pay a co-pay after reaching MMI, or unless I, or you are notified by the employer/carrier, through legal avenues that you have been de-authorized.

I understand that it is my responsibility to keep all of my appointments with you. I understand also that if I do not, and if I regularly miss appointments, it is then your obligation to notify the employer/carrier & my physician. To regularly or often miss my scheduled appointments is an indication that I may no longer need treatments & can therefore possibly jeopardize my case."

I agree to keep accurate records of travel to and from your facility for medical treatment because I may be able to receive travel reimbursement that may be required by my State's Workers' Compensation law.

Signed: _____ Date: _____

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:** ____/____/____