MEDICAL MASSAGE INTAKE FORM

Patient Name: _____ M____ F_____

Address:_____ State: _____ ZIP: _____

Date of Birth: _____ Email Address: _____

Phone: Cell:_____ Home: _____ Work: _____

Occupation: _____ SSN: _____ - _____ - _____

Insurance Company Name: _____

Address: _____

City:_____ State: _____ ZIP: _____

Adjuster:_____ Phone: _____

Claim/Policy #:_____ Date of Incident: _____

Name of Insured: _____ DOB: _____

Primary Care Physician: _____

Address: _____ City:_____

State: _____ ZIP:_____ Phone: _____

Attorney: _____

Address: _____ City: _____

State: _____ ZIP: _____ Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Is this case related to: Auto _____ Work _____ Other _____ Explain: _____

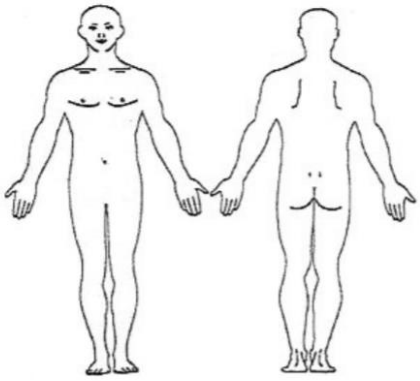
Has the insurance company been notified? Yes _____ No _____

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 _____ If Yes, for how long? _____

Please indicate with an X the places you are feeling discomfort:



What makes your condition worse? _____

_____

What makes your condition better?_____

_____

Please list all medications you are taking: _____

_____

Do you have a history of the following?

☐ Accident	☐ Varicose veins	☐ Decreased range of motion
☐ Neck Pain	☐ Surgery	☐ Broken bones
☐ Whiplash	☐ Arthritis	☐ Fibromyalgia
☐ Headaches	☐ Diabetes	☐ Cancer
☐ Disc problems	☐ Seizures	☐ Taking blood thinners
☐ Mid-back pain	☐ High blood pressure	☐ Nervous tension
☐ Low-back pain	☐ Heart attack	☐ Allergies to perfumes/oils

Have you ever received massage therapy? Yes _____ No _____

PERSONAL INJURY / AUTO ACCIDENT or SLIP & FALL CASE

Do you have No – Fault P.I.P. benefits? YES: ☐ NO: ☐

Are there benefits left? YES: ☐ NO: ☐

Do you have a deductible? YES: ☐ NO: ☐

Deductible amount? $_____ Has it been met yet? YES: ☐ NO: ☐

Were you struck from: Behind: ☐ Front: ☐ R. Side: ☐ L. Side: ☐

If other, please explain: _____

Did you feel pain immediately? YES: ☐ NO: ☐ If YES, where: _____

If NO, when did you first start feeling pain? _____

Since the injury, are your symptoms: Getting worse: ☐ Improving: ☐

Staying the same: ☐ Changing: ☐

(If changing, please explain):_____

_____

Were you the: Driver: ☐ Passenger: ☐ Pedestrian: ☐ Other: ☐_____

Have you received massage therapy for this medical condition? YES: ☐ NO: ☐

Have you received massage therapy for any medical condition in the past? YES: ☐ NO: ☐
If YES, did it help? YES: ☐ NO: ☐

If you live in a state that is not a no-fault state or do not have MED-PAY on your policy, you must supply the following information.

INFORMATION ON DRIVER OF VEHICLE AT FAULT:

Name: _____ Phone: _____

Address: _____

Policy #: _____

Have you obtained an attorney for this case? YES: ☐ NO: ☐
If YES, please fill out our Attorney Letter of Protection and provide your attorney's name, phone and fax numbers.

MEDICAL RECORDS RELEASE FORM

Patient Name: _____ DOB: _____

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 copy 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: _____

Heaven & Health, LLC 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, judgement, verdict or other sources, that may become available to protect Heaven & Health, LLC's outstanding bills, by making direct payment for our bills, to Heaven & Health, LLC, 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 Heaven & Health, LLC.

Heaven & Health, LLC 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 that 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, Heaven & Health, LLC may then begin collection proceedings immediately, unless patient obtains a letter of protection from another law firm immediately.

Heaven & Health, LLC 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.

Heaven & Health, LLC, 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: _____

Street City State ZIP

Massage Office: Heaven & Health, LLC Phone: 302-999-9565 Fax: 302-999-0025

Address: 270 Presidential Dr. Greenville, DE 19807

Therapist Signature: _____ Date: _____