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: _______________________________

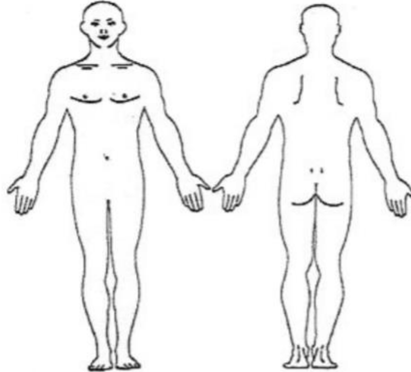
Has the insurance company been notified? Yes _____ No _____

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

Please explain: ____

____

◊ Have you ever had a Workers' Compensation claim before? Yes ☐ No ☐

◊ Since the injury, symptoms are: Improving ☐ Worse ☐ Same ☐ Changing ☐

Please explain: ____

____

____

◊ Explain in detail how your accident happened: ____

____

◊ Any other comments about your injury or treatment you have received that you wish to add:____

____

____

(OVER)

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 and my physician. To regularly or often miss my scheduled appointments is an indication that I may no longer need treatments and 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: ______________________

<u>MEDICAL RECORDS RELEASE FORM</u>

Patient Name: ____ DOB: __________________

To Provider of Services: <u>Heaven & Health, LLC</u>

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: <u>Heaven & Health, LLC</u>

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: _________________