Motor Vehicle Accident
Patient Insurance Information Form

Mr. Her's Massage, LLC
John Her, LMT #19789 NPI#1053758961

Patient's Name: _____
(As shown on Insurance Card) Last Name First Name Middle Initial

Gender: _____ Driver's License # And State: _____

Date of Birth: _____ Marital Status: Single _____ Married _____ Other _____

Patient's Address: _____

City _____ State: _____ Zip Code: _____

Contact Phone: _____ Best Time to Contact: _____

Emergency Contact: _____ Phone: _____

Patient's Employer: _____ Phone: _____

Patient's Signature: _____

Parent/Legal Guardian Signature if patient is a minor: _____

Insured's Information if different from the Patient

Insured OR Guarantor's Name: _____

Insured's Birth Date: _____

Did Accident Occur While Driving A Company Vehicle? Yes No

Insured's Employer: _____ Employer's Telephone: _____

INSURANCE PLAN AND RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Insured's Claim Number: _____ Policy #: _____

Insurance Company Name: _____

Insurance Company Billing Address: _____

Phone: _____ Fax: _____ Claim Representative: _____

Date of Accident: **State Accident Occurred In:**

Name of Referring Physician: _____

Physician's Office Address: _____

Physician's Phone Number: _____

PLEASE REVIEW THE INFORMATION YOU HAVE PROVIDED TO ENSURE THE CORRECT DATA FOR YOUR CHART AND BILLING INFORMATION. PATIENTS ARE RESPONSIBLE FOR KEEPING THIS DATA UPDATED WITH EACH VISIT TO ENSURE TIMELY BILLING AND COLLECTIONS.

Insurance is considered a method of reimbursing the PATIENT for fees paid to the practitioner and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not covered or reimbursed by your insurance carrier.

By signing this information form, I have been informed that it is my responsibility to contact my insurance carrier to verify that any and all authoritiation have been obtained prior to this visit. I understand that I am responsible for payment in full for all services rendered regardless of insurance. If this account is assigned to any attorney for collection and/or suit, the practice shall be entitled to attorney fees and costs of collection.

Initials: _____

Authorization of insurance benefits: I authorize insurance payments to go directly to Mr. Her's Massage, LLC. If payments are defaulted to me, I agree to pay Mr. Her's Massage, LLC for all medical services provided. I authorize the release of any information necessary to determine liability for and to obtain reimbursement of any claim. This assignment shall remain in effect until revoked in writing by me. A photocopy of this assignment is to be considered as valid as the original.

Initials: _____

INSURED'S SIGNATURE: _____ **DATE:** _____

Mr. Her's Massage, LLC | 10490 SW Eastridge St Suite 110C Portland, OR 97225 | 503-863-8771 will be submitting the claim for services rendered to your insurance carrier. We encourage you to concat Mr. Her's Massage, LLC if you have any questions or need further assistance.

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights converting those records. Before we begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this massage practice to use their Patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care. As an example, the patient agrees to allow this massage practice to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for th e purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our practice is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all the staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this clinic to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent form for the purpose of treatment, payment and health care operations, the licensed massage therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

Mr. Her's Massage, LLC
10490 SW Eastridge St Suite 110C
Portland, OR 97225
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HISTORY OF AUTO ACCIDENT/SUBSEQUENT SYMPTOMS

Patient Name: _____

Date of accident: _____ Time: _____am/pm # of people in vehicle: _____

Mark One

You were the:

- ☐ Driver
- ☐ Passenger
- ☐ Behind The Driver
- ☐ Middle
- ☐ Behind Passenger

Where was the accident?

City: _____ Street: _____ Cross Street: _____

Type of care you were in: _____ Other Vehicle(s): _____

Description of Accident: _____

_____

_____

Did the police or ambulance come to the accident scene? Yes No

Were you wearing a seatbelt? Yes No Airbags Deployed? Yes No

Did you brace for the impact? Yes No

Explain Head/Arm/Body position at time of impact:

_____

Did any part of your body hit inside the vehicle? Yes No

Explain: _____

Did you get any cuts or bruises? Yes No

Where? _____

Did you go to the hospital or see another doctor? Yes No Date of 1st visit: _____

Were x-ray/MRI's taken? Yes No

Explain:_____

Were you given treatment? Yes No

If yes, what type of treatment? _____

Do you feel you can work without pain? Yes No

What is your job? _____

Similar symptoms in the past? Yes No

Explain. _____

Past Health History

Do you take any medications? Yes No

Explain. _____

Past Surgurings/Hospital Stays? Yes No

Explain. _____

PAst injuries or broken bones? Yes No

Explain. _____

Previous and current illnesses? Yes No

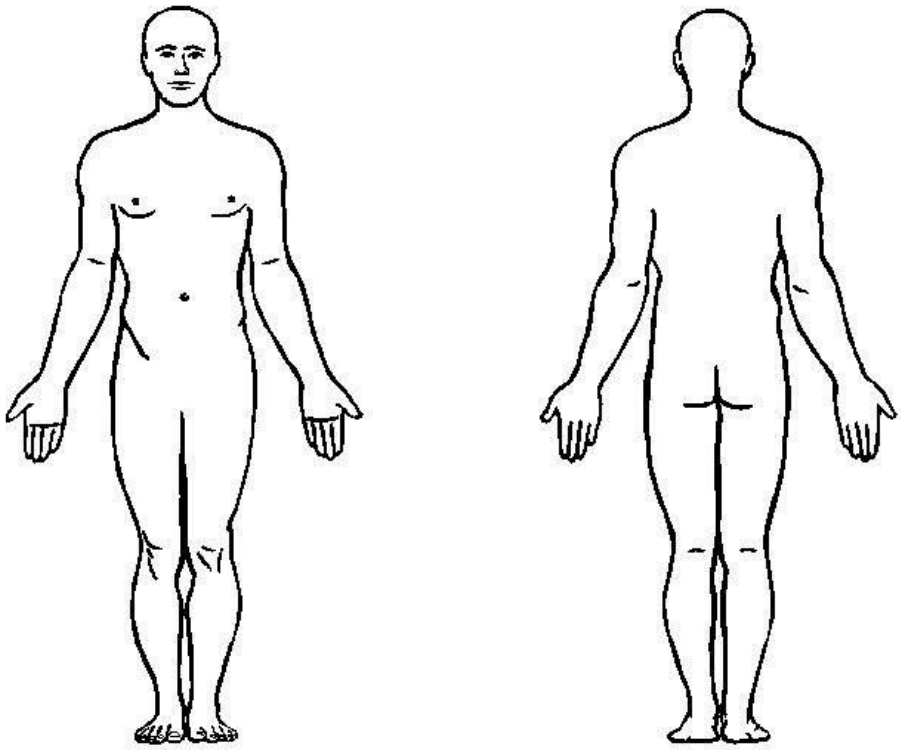
Explain. _____

Family History

_____

_____

Current Complaints: Indicate P = Pain, T = Tightness, S = Swelling, B = Burning, L = Limited Movements



Other notes:

Signature: _____ Date: ____/____/____