



Insurance Form

The following information will be used in the billing processes of your insurance. Please answer the questions to the best of your knowledge.

Kate Larson, LMT #17952

www.AppleBlossomMassage.com

541.357.2488

Legal Name _____	Phone (____) _____	
Address _____		
Email _____	DOB _____	Social Security # _____
Employer _____	Phone (____) _____	
Employer's Address _____		
Insurance Company _____	Claim # _____	
Insurance Mailing Address _____		
Subscriber ID # _____	Group # _____	
Insurance Phone (____) _____	Insurance Fax (____) _____	
Primary Care Physician _____	Phone (____) _____	
Date of Motor Vehicle Accident _____		
ICD-9 Codes _____		
Relationship to Insured _____	Prescription for massage <input type="checkbox"/>	

As a courtesy to you, I will gladly bill your insurance company for your massage services.

Ultimately, you are responsible for the charges that you incur for care but many health insurance policies will cover some or all of these expenses. Auto insurance will cover the costs of therapeutic massage for injuries sustained in a motor vehicle accident for up to one year following your accident.

Disclaimer: By signing below, I agree that if the insurance company does not pay for my massage services I will be responsible for the payments in full. I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to diagnose medical conditions. I affirm that I have stated all my known information, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Signature _____ Date _____

It is my honor to assist you on your path of well-being. -Kate Larson, Licensed Massage Therapist