Healing Balance Massage Therapy 503-772-4340
healingbalancemassage.com

Insurance Information

Insured/Patient____Date of Birth ___/___/______

Subscriber/Responsible party ____

Subscriber relationship to patient__________________Subscriber Date of birth ___/___/______

Insurance Company ___________________________ Phone #______________

ID# ___________________ Group# ________________________

I, the undersigned certify that I (or my dependent) have insurance coverage with payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Healing Balance Massage to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Patient/Responsible Party/ Parent/Guardian Signature Today's Date

Motor Vehicle Accident and Medical Referral Only

Patient Name____ Date of birth__________________

Patient Insurance Company _______________________Insurance Phone#__________________

Claim Number_____________ Adjuster Name and Phone #______________________________

Referring Doctor name and Phone # ____

Date of Injury ___/___/________

I, the undersigned certify that I (or my dependent) have insurance coverage with payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Healing Balance Massage to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Patient/Responsible Party/ Parent/Guardian Signature Today's Date

Healing Balance Massage Therapy 503-772-4340
healingbalancemassage.com

Guide to Checking Your Insurance Benefits

(This page is for your personal reference only, please keep for your records.)

Remember to call your insurance company at least 24 hrs in advance of your appointment. Call the customer service number on the back of your insurance card. Ask for benefits/eligibility. Tell the phone representative you're calling to check on your personal insurance benefits.

☐ Date/Time called: __________Name of the representative:________________________________

☐ Do I have coverage for massage performed by a Licensed Massage Therapist? Yes/No

☐ Is the following practitioner in-network with my plan? Lynn Short (NPI #1861524316) Yes/No

☐ Do I have out-of-network benefits? Yes/No
(You only need to ask this if the practitioner you want to see in NOT in network)

☐ Do I have a deductible to meet first, in regard to this service?
(This is the amount you will pay out of pocket this year before services are covered. The amount is renewed each year.)

Yes/No If Yes how much is it? $ ____________

☐ How much of my deductible do I still have to meet this year? $ _______________

☐ What is the date my insurance policy renews each year? ___________________

☐ What is my co-pay or co-insurance? _________________
(If you have a deductible, this must be met before the co-pay applies.)

☐ Is a referral required from my primary care physician? Any other pre-authorization required?

Yes/No If Yes: ____

☐ Do I have a maximum number of visits, or a maximum dollar amount for this service each year? Yes/No

☐ If Yes: Maximum # visits per year__________ Maximum $ amount per year___________

☐ How many visits have been used? How much of the dollar maximum has been used?

visits used__________ $ amount used__________