Amy Bean Reiki Master, LPTA, LMT #7081

8514 SE Stark Street, Portland OR 97216 (503) 780-1478

www.radiancehealingarts.com

Radiance Healing Arts
LET YOUR LIFE SHINE

Confidential Insurance Intake Supplement – No information will be sold, rented or shared with outside parties without your consent in the event of medical or billing necessity. Your privacy is important to me!

Please fill out all pertinent information below

Patient's Name _____ Birth date _____/_____/_____
Phone (C) _____ Phone (W) _____
Address _____
City _____ State _____ Zip _____
Employer's Name _____
****
Insured's Name _____ Insured's Birth date ___/___/___
Phone (C) _____ Phone (W) _____
Address _____
City _____ State _____ Zip _____
Insured's Employer _____
****
Referring Physician Name/Phone _____
Physician Diagnosis_____
Date of Injury_____
Condition Related to: Employment _____ Auto Accident _____ Other accident _____
****
Primary Insurance Company _____ Phone _____
Address _____ City _____ State ____ Zip _____
Adjuster's Name _____ Phone _____
Policy # _____ Group # _____
Member # _____ Claim # _____ ID# _____
Type: Group _____ PIP/Auto _____ Worker's Compensation _____
Is there a supplemental health benefit plan? _____

*(Please Initial)*_____ **Please Note – You are responsible for all payments denied by your insurance company. Insurance billing is provided to you as a courtesy. However, the full payment for the cost for each massage therapy session is yours. Whatever portion of the session(s) denied by third party insurance is your responsibility to pay, including but not limited to copayment, deductible and coinsurance.**

Release: I authorize the release of any medical or other information necessary to the medical treatment of my condition and to process this claim. I also request payment of medical benefits either to myself or to this medical provider.

Signature_____ Date _____

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Please be advised of our office policies. Your signature below signifies acceptance of these policies.

Cancellation
A 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the appointment. Payment is due before your next appointment.

Tardiness
Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Illness
Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

If this office is providing billing services, please be advised of our billing policies.
(Please Initial) _____

Insurance billing is provided to you as a courtesy. However, the full cost of each session is your responsibility. Whatever portion of the session(s) unpaid by your insurance is your

Cancellation
We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility
Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement. Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays and rebilling fees. NOTE: Balances are subject to a $10 rebilling fee if not paid in full on receipt.

Assignment of Benefits
Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records
Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature_____ Date _____