Amy Bean Reiki Master, LPTA, LMT #7081
8514 SE Stark Street, Portland OR 97216 (503) 780-1478
www.radiancehealingarts.com

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 _____/_____/_____ Circle: M F

Address ____ Phone (C) ___________________

City _________________________ State _____ Zip _________ Phone (W) ___________________

Employer's Name ____

****

Referring Physician Name/Phone ____ Date of Injury_________

Physician Diagnosis_____________________________________

Condition Related to: Employment _____ Auto Accident _____ Other accident _____

****

Insured's Name _______________________________________ Insured's Birth date ___/___/___

Address ____ Phone (C) __________________

City __________________________ State _____ Zip _________ Phone (W) __________________

Relationship to Insured (circle) Self/Spouse/Child Insured's Employer _______________________________

****

Insurance Company ____ Phone _____________________

Address _______________________________________ City ________________ State _____ Zip ___________

Adjuster's Name ____________________________________ Phone __________________________________

Policy # _________________________ Group # ______________________ Member # __________________

Claim # _________________________ ID# ____________________________

Type of Insurance: Group _____ PIP/Auto _____ Worker's Compensation _____

Is there a supplemental health benefit plan? _____

The responsibility for the cost for each massage therapy session is the client's. Whatever portion of the session(s) denied by a third party payer is the client's responsibility. *(Please Initial)*_____

Release: Authorized signature: 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 __________________

Revised 1-16