LIFETOUCH MASSAGE & WELLNESS
Insurance Intake Form

Worker's Compensation Injury Billing Information (if applicable)
Complete information is needed in order to process your claim.

Name of employer: _____

Worker's compensation insurance carrier:_____

Address of carrier: _____
Street City State Zip

Adjuster's name: _____ Adjuster's phone: _____

Claim #:_____

Auto Accident Injury Billing Information (if applicable)
Complete information is needed in order to process your claim.

Name of no-fault insurance company: _____

Name of the policy holder: _____

Relationship to the policy holder (self, spouse, child, other):_____

Address of insurance company: _____
Street City State Zip

Ins. company phone #: _____ Adjuster's name:_____

Policy #: _____ Claim #:_____

Release and Assignment (please read and sign below)

I hereby consent and authorize the administration of all procedures. I hereby authorize LifeTouch Massage and Wellness to release or obtain any information to the insurance company, attorney, or referring physician upon request. I also assign and request payment of medical benefits to LifeTouch Massage and Wellness.

I also understand that I am financially responsible for any charges not covered by my insurance carrier.

Printed Name:_____

Patient's Signature: _____ Date:_____