

Therapeutic Massage & Body Care

1343 Wantagh Avenue

Wantagh, NY 11793

Phone: 516-679-8299

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RE: Reports and Therapist’s Lien

Patient: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I do hereby authorize the above Therapist (as per referring Doctor) to furnish, my Attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself in regard to the accident in which I was involved.

I hereby authorize and direct you, my Attorney, to pay directly to said Therapist such sums as may be due his/her office and to withhold such sums from any settlement, judgement, or verdict as may be necessary to adequately protect said therapist. And I hereby further give a lien on my case to said Therapist against any and all proceeds of any settlement, judgement, or verdict which may have been paid to you, my Attorney or myself as the result of the injuries for which I was been treated or injuries in connection herewith.

I understand that I am directly and fully responsible to said Therapist for all medical bills submitted by him/her for service rendered me and that this agreement is solely made for the Therapist’s additional protection and in consideration of him/her awaiting payment. And I further understand that such payments are not contingent on any settlement, judgment or verdict by which he/she may eventually recover said fee.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This undersigned being Attorneys of record for the aforementioned patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgement or verdict as may be necessary to adequately protect said Therapist above named.

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Attorney’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney: Please date, sign and return to Therapist’s office at once.

Reply envelopes attached. Keep one copy for your records.

No Fault/Workers Comp

Patient Information

# Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Insurance Information

# Worker’s Comp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No Fault Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeing any PT, Chiro, or other LMT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adjuster’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Check List (Front Desk Staff)

Prescription: Yes\_\_\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receiving Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Verified – Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spoke To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claim Open/Can Submit Bills\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address To Send Bills\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can Have Concurrent Treatment: Yes\_\_\_\_\_\_\_\_\_No\_\_\_\_\_\_\_\_



1343 Wantagh Avenue

Wantagh, NY 11793

(516) 679-8299

**Confidential Information**

Welcome. We want to make your visit as pleasant and comfortable as possible.

If at any time you have any questions or concerns, please let us know.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive texts: Y / N Emails: Y / N about upcoming appointments?

If you would like to receive text messages, what cellphone carrier do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received massage therapy before? Y / N - If so what type? Deep tissue? Y / N Swedish? Y / N Other? Y / N

What medication do you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you consumed alcohol in the past 24 hours? Y / N

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a history of any of the following? Please Check

 Please Mark Area(s) of Pain

|  |  |  |
| --- | --- | --- |
| Accidents | Disk Problems | Joint Aches |
| Headaches | Lower Back Pain | Abdominal Pain |
| High Blood Pressure | Cancer | Diabetes |
| Allergies to oils/perfumes | Wear contacts or otherprosthesis | Decreased Range ofMotion |
| Stroke | Colitis | Whiplash |
| Varicose Veins | Heart Attack | Mid Back Pain |
| Surgery | Seizures | Arthritis, bursitis, gout  |
| Broken Bones | Nervous Tension | Breast augmentation |
| Neck Pain | Sprains | HIV |
| Fibromyalgia | T.M.J. | Other |

Do you have any of the following today?

|  |  |
| --- | --- |
| Sunburn | Inflammation |
|  Severe Pain | Headache |
| Open Cuts, bruises, burns | Irritated Skin Rash |
| Poison Ivy | Cold/Flu |

 Is there anything else that we should know?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand this massage is not a replacement for medical care and that no diagnosis will be made. I am responsible for paying for any appointment cancellation of less than 24 hour. If this office is submitting paperwork to my insurance carrier, I authorize the release of any medical or other information necessary to process an insurance claim. I authorize payment of medical benefits to the Licensed Massage Therapist or office listed above, for services tendered.

**Signature Date**