TALLAHASSEE MASSAGE THERAPY, INC.

224 LAFAYETTE CIRCLE
TALLAHASSEE, FL 32303
(850) 681-2122

Date _____ Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____
Address _____
City _____ State _____ Zip _____
Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ married ☐ Other
Occupation _____ Business phone _____
Mobile Phone _____ Email Address _____
Who may we thank for referring you? _____
In case of emergency who should be notified? _____ Phone _____

PAYMENT/INSURANCE INFORMATION

☐ Cash/Check/Credit ☐ Major Medical ☐ P.I.P. (Person Injury - Auto Insurance)

Please complete the information below if billing insurance for payment

Insurance Company _____
Contract # _____ Group # _____
Person responsible for account _____
Policy Holder (if other than self) _____ ☐ Spouse ☐ Child ☐ Other
Address (if different than patient) _____ Phone _____
City _____ State _____ Zip _____
ACCIDENT INFORMATION: Claim # _____ Adjuster: _____
Date of Accident: _____ Type of Accident: _____
Amount of Deductible _____ Has it been met (yes/no)? _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with:

_____.
Name of Insurance Company

I agree to pay for services rendered in full at time of service. I agree to allow Tallahassee Massage Therapy to submit claims and benefits which will be payable to me for reimbursement. I hereby authorize my referring physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

OVER PLEASE

HEALTH INFORMATION

What is the reason for your visit? _____

How long has this been an issue? _____

What makes it better or worse? _____

CHECK (✓) SYMPTOMS YOU ARE EXPERIENCING TODAY

☐ Pain ☐ Numbness ☐ Tightness ☐ Weakness ☐ Other _____

In these areas:

☐ Head ☐ Neck ☐ Shoulders ☐ Arms ☐ Hands ☐ Wrists ☐ Upper Back ☐ Lower Back ☐ Thighs

☐ Knee(s) ☐ Calves ☐ Ankle(s) ☐ Feet ☐ Other _____

CONDITIONS YOU HAVE HAD IN THE PAST

☐ ACCIDENTAL INJURY
☐ ACUTE INFECTION
☐ AIDS
☐ ALLERGIES
☐ ANEMIA
☐ ARTHRITIS
☐ ASTHMA
☐ BLEEDING DISORDERS
☐ BRONCHITIS
☐ CANCER

☐ CHICKEN POX
☐ CHRONIC PAIN
☐ DIABETES
☐ EMPHYSEMA
☐ EPILEPSY
☐ FIBROMYALGIA
☐ GOITER
☐ GOUT
☐ HEART DISEASE
☐ HEPATITIS
☐ HISTORY OF SURGERY
☐ SITE_____

☐ HERNIA
☐ HERPES
☐ HIGH CHOLESTEROL
☐ HIV POSITIVE
☐ KIDNEY INFECTION
☐ MEASLES
☐ MIGRAINE HEADACHES
☐ MULTIPLE SCLEROSIS
☐ OSTEOPOROSIS
☐ OTHER_____

☐ POLIO
☐ POOR CIRCULATION
☐ PHLEBITIS
☐ PMS SYNDROME
☐ PREGNANT _____
Please indicate months pregnant
☐ SCIATICA
☐ SPORTS INJURY
☐ STROKE
☐ TMJ SYNDROME
☐ VARICOSE VEINS

TALLAHASSEE MASSAGE THERAPY POLICIES

CANCELLATIONS: We reserve the right to charge you, the patient or insured (not the insurance company), for appointments cancelled or broken. Please avoid paying for a missed appointment. IT IS YOUR RESPONSIBILITY TO CANCEL 24 HOURS IN ADVANCE.

REASON: Your appointment time is reserved expressly for you. Anything less than 24 hours notice is not enough time for the therapist to re-schedule your appointment time with another patient.

CO-PAYMENTS: Co-payments are required on the day service is rendered.
No co-payment is required if the insured's contract pays 100% of charges. **If your insurance company delays or denies payment, we at Tallahassee Massage Therapy will do our best to supply the insurance company with any further information or paperwork needed for processing the claim. Please note that ultimately you, the patient, will be responsible for paying for unpaid claims.**

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I have read and clearly understand Tallahassee Massage Therapy's insurance billing policy.

_____ Patient's Signature

_____ Date