

Billing Information

Emerald Vine Massage

142 NW Canal St. Seattle, WA 98107 • p. 206.347.0777
massage@emeraldvine.net • f. 888.254.3281

Patient Information

Address: _____
City: _____ State: _____ Zip: _____
Phone: Home: _____
Work: _____ Cell: _____
Date of Birth: _____ Male Female
Marital Status: Single Married Partnered
Relationship of Patient to Insured: Self Spouse
 Partner Child Other
Employer/School Name: _____

Part-time Full-time

Phone: _____ Fax: _____

Is the patient's condition related to:

Employment: Yes No

Auto Accident: Yes No

If Auto Accident, in what state? _____

Other Accident: Yes No

Illness: Yes No

Primary Health Care Provider (your referring doctor):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Attorney:

Has an attorney been consulted? Yes No

Retained? Yes No

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Insured (your spouse/parent/etc, if you are covered under their plan):

Name: _____

Insurance ID#: _____

Date of Birth: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Employer/School Name: _____

Phone: _____ Fax: _____

Patient Name: _____

Current Date: _____ Date of Injury: _____

Insurance/Claim ID#: _____

Social Security #: _____

Primary Insurance Coverage

Insurance Carrier: _____

Contact: _____

Group #: _____

Plan # and/or Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Secondary Insurance Coverage

Insured: _____

Insurance ID#: _____

Date of Birth: _____ Male Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

Employer/School Name: _____

Phone: _____ Fax: _____

Insurance Carrier: _____

Group #: _____

Plan # and/or Name: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Assignment of Benefits:

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

Release of Medical Records:

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.

Financial Responsibility:

I understand that it is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes partial payment, I am responsible for the balance, and will receive 30 days notice of the charges due. Charges unpaid after 30 days will be assessed interest at the rate of 25% per month. If my practitioner has contracted with my insurance company and the agreed-upon fee has been satisfied, the balance will be waived.

Signature: _____ Date: _____