Insurance Information Form

Daniel J. Morrissey LMT
503-258-0479 massage@danielmorrissey.com

Name: _____ Date of Birth: _____ Gender:_____

Address:_____ Phone#: _____

Email: _____

Health Insurance Information

Primary Insurance Company:_____

Policy Holder:_____
& Relationship to patient

EDI#:_____

Patient ID#:_____

Group Plan#:_____

Auto Accident Information

Accident date:_____/_____/_____

Claim Filed: Yes / No

Insurance Company:_____

Claim#:_____

Adjuster's name, phone & email:_____

_____

Assignment and Release
I, the undersigned, certify that I (or dependent) have insurance coverage with the above company. I assign all insurance benefits, if any, otherwise payable to me for services rendered, directly to Daniel Morrissey LMT or authorized associate(s) providing my my massage therapy care in cooperation with Daniel J. Morrissey. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Date: _____/_____/_____
Signature of Patient or Guardian if patient is a minor