

Essential Wellness, NW

PERSONAL INJURY PROTECTION "PIP" INSURANCE QUESTIONNAIRE

Patient: _____ SS # _____

Address: _____
Street City State Zip

Date of Birth: _____ Sex: () Male () Female Employed () Yes () No

Home Phone: _____ Work Phone: _____

Cell: _____ E-Mail: _____

Employer: _____

Emergency Contact: _____ Phone: _____

Auto Accident: () Yes () No Other Accident: _____

Date of Injury: _____ Cause: _____

Location: _____

Name Of Insured: _____

Your Primary Auto Insurance: _____

Billing Address: _____
Street City State Zip

Adjuster: _____ Phone: _____

Claim #: _____ Policy # _____

Attorney: _____ Phone: # _____

Address: _____
Street City State Zip

Third Party/At Fault: _____

Third Party/At Fault Insurance Company: _____

Insurance Address: _____
Street City State Zip

Claim#: _____ Phone: _____

Referring Physician: _____ Phone #: _____

Address: _____
Street City State Zip

Signature of Patient: _____ Date: _____

Essential Wellness, NW

PATIENT HISTORY

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

E-Mail: _____ Occupation: _____

Is this your first professional massage therapy session? _____

Please state your reasons for seeking massage therapy. _____

Please state any recent injuries, illness, accidents or surgery. _____

Do you have or have you had any of the following? If so, please check appropriate boxes.

Present	Past		Present	Past		Present	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Localized Infection	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headache
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerated Colon	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cysts
<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Osteo-Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian/Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>	Lumbago
<input type="checkbox"/>	<input type="checkbox"/>	Neck/Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Ailments
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Communicable Illness	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory/Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Heart Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Acute Inflammation	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	TMJ
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Fever			

Are you currently under the care of a physician? _____ Whom: _____

Please list any medication taken now or at regular intervals: _____

Who referred you to me?: _____

The above information is true and accurate to the best of my knowledge. I agree to pay for my massage treatments by cash or check at the time of treatment (unless covered by pre-arranged insurance claim); I also agree to pay for any missed appointment for which 24 hour notice has not been given.

Signature: _____ Date: _____

8351 - 160th Avenue NE Avenue NE ♦ Redmond, WA 98052
Phone (206) 250.4151 ♦ Fax 425-881-1022
www.EssentialWellnessNW.com

Essential Wellness, NW

POLICES FOR DEFERED PAYMENT

Inner Balance is both a Wellness therapy Clinic and a facility designed to care for specific conditions diagnosed by a licensed physician. Our relationship is with YOU, the patient. We are happy to bill insurance carriers as a courtesy and convenience for you. If a claim is not accepted or payment is delayed in any way, we will assist you in whatever way possible to expedite or effect payment. However, you as the patient are responsible directly to the therapist for payment of your account.

WORKMAN'S COMPENSATION

If your claim has not been accepted by the Department of Labor and Industries at the time of your initial visit, we will still begin muscular care for up to six visits. Although we will bill directly to the Department of Labor and Industries for you, you are still ultimately responsible for payment of your account. If the claim is accepted by the Department of Labor and Industries, we will establish that a need for additional care exists beyond the first six sessions. If a need for additional care exists, all future sessions must be determined by your doctor and authorized by the Department of Labor and Industries before we can schedule additional sessions. If your claim is rejected by the Department of Labor and Industries you are responsible for payment of your account with the individual therapist.

PERSONAL INJURY/ACCIDENT CLAIMS

These types of claims are processed in one of three ways:

1. **Personal Injury Protection (PIP Claims):** If you have personal injury protection coverage under your automobile insurance, we require that this feature be utilized for payment of your account. We will bill your own auto insurance carrier and your auto insurance carrier will pay your medical bills immediately, weather or not you were at fault in the accident. When the claim is resolved, the responsible driver's auto insurance carrier will reimburse your insurance carrier for medical payments advanced on your behalf. Your own insurance coverage and standing are not adversely affected by this payment arrangement. With PIP claims, we request that you direct your auto insurance carrier to make PIP payments directly to us to expedite the payment process.
2. **Major Medical:** If you did not have PIP coverage at the time of your accident, and you have an acceptable major medical insurance carrier, we will defer payment on claims submitted to your major medical carrier providing there is verification that they will pay for the services of a LICENSED MASSAGE PRACTITIONER (not a physical therapist). Each case will be verified before treatment will begin.
3. **Third Party or UIM Claims:** Where there is not PIP coverage, we will review your claim and determine weather we can provide treatment on credit until you claim is resolved. As a condition of accepting your case, you must obtain an attorney. You must also agree that your account will be paid in full before you or your attorney receive any funds from your settlement. If all conditions to provide treatment on a deferred basis are satisfied, and annual processing fee of \$20.00 must be paid to the therapist at the time treatments commence.

MAJOR MEDICAL CLAIMS

If a patient desires to submit any bill to an insurance carrier, we will gladly provide a statement of services when you make payment at the time of your visit. This statement, and your Doctor's prescription, can be presented for reimbursement to your insurance carrier. If you pay for treatment at time of service, you will be billed at the cash discount rate. If you would like for us to bill you insurance carrier directly, you will for go the cash discount. Please check with your therapist to make these arrangements.

OUR RELATIONSHIP TO YOU

It is understood that the deferring of payment whether by special arrangement, or incident to the processing of Insurance claims, is and EXTENSION OF CREDIT to you, by the therapist. Charges on your account remaining unpaid, for any reason for a period of 60 days or longer are subject to a 1% per month finance charge. Patient's signature to a Deferred Payment Policy Form indicates that the undersigned has waived his/her right to pre-pay their account at the cash discount rate. In the event that we must enter into arbitration or collection processes to secure payment of unpaid balances, the undersigned agrees to pay all collection and attorney's fees incurred by such action.

I authorize the release of any and all information the therapist deems necessary for the processing of payment of my account.

I hereby authorize and direct my medical benefit provider to make payment of my medical benefits directly to the treating practitioner.

Signature: _____ Date: _____

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