Essential Wellness, NW

WORKER'S COMPENSATION 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:**_____

Date of Injury:_____ **Cause:**_____

_____

Body Area Requiring Treatment:_____

Labor & Industries ( ) Yes ( ) No **Self-Insured Company ( ) Yes ( ) No**

Insurance Name:_____ **Phone #:**_____

Insurance Address:_____
Street **City** **State** **Zip**

Claim #:_____ **Claim Manager:**_____

Attorney:_____ **Phone: #:**_____

Address:_____
Street **City** **State** **Zip**

Referring Physician:_____ **Phone #:**_____

Address:_____
Street **City** **State** **Zip**

Signature of Patient:_____ **Date:**_____

8351 – 160th Avenue NE ◆ Redmond, WA 98052
Phone (206)-250-4151 ◆ Fax: 425-881-1022
www.EssentialWellnessNW.com

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

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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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