8221 NE Hazel Dell Ave
Vancouver WA 98665
Phone/SMS: (360)334-6373
Fax: (360)583-3559
Email: flourishLMT@gmail.com

Insurance Information

Name:_____ Date of Birth:_____

Phone Number:_____ ⬜Call -OR- ⬜Text

Insurance company: _____

Provider phone number:_____

Insurance ID# (include alpha prefix):_____

Please complete the top portion and email to flourishlmt@gmail.com with a copy (Front and Back) of your insurance card.

OFFICE USE

Client Identifier:_____

Date:_____ Time:_____

⬜ IN NETWORK ⬜OUT OF NETWORK

Representative:_____

Reference #:_____

Are there out-of-network benefits available? ⬜Yes ⬜No

Does the insurance plan cover massage therapy? ⬜Yes ⬜No

Does the treatment have to be pre-authorized? ⬜Yes ⬜No

Rx Required ? ⬜Yes ⬜No

Annual massage therapy benefit

visits _____/_____ -OR- $_____/$_____

What is the deductible? $_____ Remaining? $_____

Copay $_____ Coinsurance _____%

Notes: