MVC/L&I Billing Information

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

Patient Name: _____ Date of Injury: _____

If "yes": ⬜ Job Related ⬜ Auto Accident ⬜ Other:_____

Referring Physician: _____ Phone:(_____)_____

Worker's Compensation (Additional information is necessary if billing State or Federal Labor Insurance)
Have you received any massage/bodywork for this injury/claim? ⬜ Yes ⬜ No

# of sessions: _____ Date claim opened: _____ Dates of coverage: _____

Insurance Company (Yours)

Insurance Company: _____ Claim Number: _____

Claims Adjuster: _____

Phone:(_____)_____ Fax:(_____)_____

FOR BILLING
Claims Address: _____ City: _____ State _____ Zip _____

Fax:(_____)_____ Email:_____

Third Party Insurance Company (Theirs)

Insurance Company: _____ Claim Number: _____

Claims Adjuster: _____

Phone:(_____)_____ Fax:(_____)_____

FOR BILLING
Claims Address: _____ City: _____ State _____ Zip _____

Fax:(_____)_____ Email:_____

Medical Release **Please read carefully!**

➜I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences,billing statements and any other information to my attorneys, health care providers and insurance case managers.

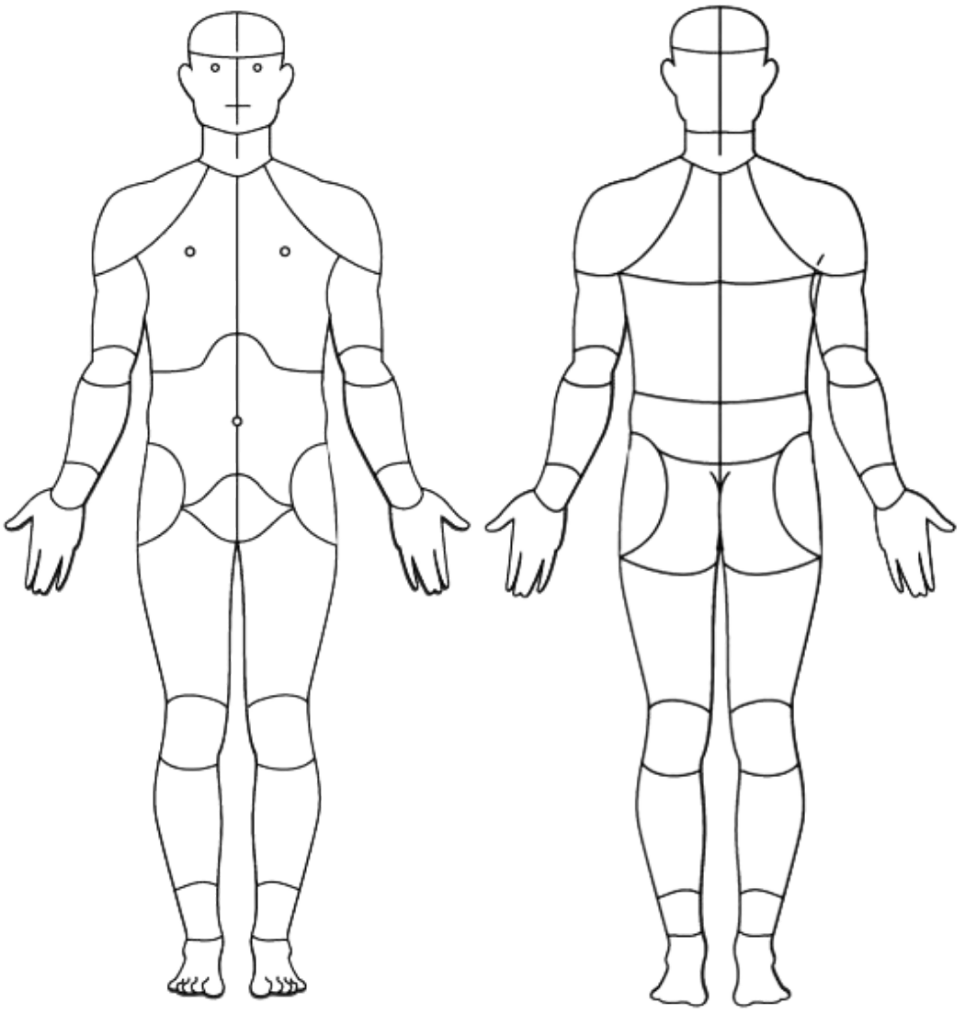
Financial Policy

➜As a patient of this office, I am responsible for all charges incurred. If my car accident claim is denied, I am fully responsible for prompt payment. If my PIP claim is not open and payable, or my medical insurance denies payment. I will be required to pay out of pocket for my visit(s).

Store Policies & Consent to Treat

➜I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
➜I am aware of the "no call/no show policy. If I fail to show up to my appointment with no notice, I am responsible for 75% of my session fee. (Please note that insurance companies do not pay this, you do).

I understand all of this, I give consent to receive care.
UNDER 18?
Client Signature(Parent/Guardian): _____ Date: _____



Please Circle any areas of discomfort and rate your pain or tension on a scale from 1-10 for each area.

0 - No Pain

1-3 - Mild Pain
●bothersome, annoying, irritating, nagging.

4-5 - Moderate Pain
●aggravating, grueling, upsetting, frustrating.

6-7 - Severe Pain
●miserable, fierce, gnawing, piercing.

8-9 - Very Severe Pain
●dreadful, overwhelming, horrible, agonizing.

10 - Worst Possible Pain
●unbearable, devastating, crushing, excruciating.

- Have you been suffering from headaches since your motor vehicle collision? ⬜ Yes ⬜ No
  - How frequently? _____
  - How long do they last? _____
  - Do they wake you up in the middle of the night? ⬜ Yes ⬜ No

- Where were you sitting? ⬜ Driver ⬜ Passenger (front or back seat)
- If you were driving, did you have your hands on the steering wheel? ⬜ Yes (top or bottom) ⬜ No
- Were you looking into your rearview mirror over your shoulder? ⬜ Yes ⬜ No
- Were you at a complete stop? ⬜ Yes ⬜ No _____
- Were you on ⬜ the freeway ⬜ a city street ⬜ in a neighborhood?
- Can you guess how fast the other vehicle was going? _____
- What angle did you get hit from? ⬜ Front (straight on, driver front, passenger front)

  ⬜ Back (straight on, driver back, passenger back) ⬜ Driver side (straight on, front, back)

  ⬜ Passenger side (straight on, front, back)
- Did your vehicle get pushed into another vehicle? ⬜ Yes ⬜ No
- Did your vehicle roll, spin, or slide due to the force of the collision? ⬜ Yes ⬜ No

Please give a full description of what occurred at your time of injury: