PRANA Therapeutic Massage
INDIGO WELLNESS CENTER 320 Liberty St. SE, Salem, OR 97301
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www.indigowellnesscenter.com

INSURANCE BILLING INFORMATION

Client Name:_____ Today's Date:_____

Check One: ☐ AUTO CLAIM ☐ HEALTH INSURANCE

Please fill out one section below, relating to either an auto claim or health claim.

AUTO INSURANCE INFORMATION			
Insurance Provider		**Date of Injury**	
Insurance Address			
Policy Number		**Insurance Phone**	
Claim Number		**Insurance Contact**	
Name of Insured		**Relation to Patient**	
Attorney (if any)		**Attorney Phone**	
Referring Physician		**Physician Phone**	

HEALTH INSURANCE INFORMATION	
Insurance Provider	
ID Number	
Group Number	
Name of Insured	
Insured Relation to Patient	

INSURANCE AUTHORIZATION AND RECORD RELEASE AGREEMENT

I authorize the release of medical records necessary to process this claim. I authorize payment by the insurance company to be made directly to the service provider.

I understand the fees for servives rendered will be directly billed to the above listed insurance company. I understand that I will be billed and held responsible for any fees for any services unpaid or not covered by the insurance company.

Printed Name:_____

Signature:_____ Date:_____