SISTER ROSALIND GEFRE MASSAGE **HIGHLAND / BURNSVILLE**
Insurance Form **Clinic**

PERSONAL INFORMATION:

Name:____

Address:_____________________________City/State/Zip:_____________________

Home Phone: (_____)_________________Work: (_____)______________________

SS#:_________________________D.O.B:_____________Sex: ___Male ___Female

INSURANCE COMPANY: _______________________Phone: (____) ____________

Claims Address: ____

City/State/Zip:____

Claim # ____________________________Policy #___________________________

D.O.I.___________1st D.O.S ___________Re. Physician: ______________________

Physician Phone: (_____) _____________ Address: __________________________

Diagnosis Code(s) ___________________________CPT Code_________________

Do you have legal representation pertaining to your workers comp or motor vehicle accident? Y / N If yes, please provide information.

Attorney Name ________________________________Phone: _________________

I authorize the release of any medical or other information necessary to process claims for payment. Sister Rosalind Gefre Massage does not suggest or guarantee payment by filing claims on my behalf for Insurances purposes. I understand that my insurance is an agreement between the insurance company and myself and I will be accountable for any unpaid balances along with cost accrued due to collections, attorney fees and /or court costs.

Patient Signature:____________________________Date:______________________