ADVANCED BODY SOLUTIONS, Inc

Patient Demographic Information

Patient Legal Name:_____
(First) (Middle Initial) (Last)

Preferred Nickname:_____ Date of Birth:_____/_____/_____

Gender:_____ SSN:_____ Marital Status:_____

Address:_____
(City) (State) (Zip)

Home/Cell Phone #:_____ Work Phone #:_____

Email Address:_____

How did you hear about our clinic?:_____

Emergency Contact

Name:_____ Relationship:_____ Phone #:_____

Financial Responsible Party (Guarantor)

Name:_____ Relationship:_____ Phone #:_____

Address:_____
(City) (State) (Zip)

Primary Insurance Information ☐Private Insurance ☐Auto Claim ☐Workers Comp Claim

Carrier Name:_____

ID #:_____ Group #:_____

Relationship to insured: Self Spouse Child Other

Subscriber Name:_____ Date of Birth:_____/_____/_____

*If Auto or Workers Comp claim: Date of Injury:_____/_____/_____

*Adjuster Name:_____ Phone #:_____

Secondary Insurance Information ☐Private Insurance ☐Auto Claim ☐Workers Comp Claim

Carrier Name:_____

ID #:_____ Group #:_____

Relationship to insured: Self Spouse Child Other

Subscriber Name:_____ Date of Birth:_____/_____/_____

Consent to Treatment: By signing below, I do hereby voluntarily consent to be treated with Massage / Manual Therapy by an Alaska State Licensed Massage Therapist at Advanced Body Solutions, Inc. I understand that massage is designed for the purpose of relaxation, relief from tension, muscle spasms, and poor circulation and massage therapists cannot diagnose medical issues/diseases/disorders or perform spinal manipulations.

Assignment and Release of Benefits: I hereby authorize Advanced Body Solutions, Inc. (NPI: 1447577200) to submit claims for medical services provided to me to my insurance carrier on my behalf and to receive payment directly from my insurance carrier for those services. I understand that this authorization allows the release of necessary medical information to my insurance for claims processing. I approve the use of electronic records and signatures. This signature will be kept on file by Advanced Body Solutions, Inc.

Patient / Guardian Signature:_____Date:_____