Print Form

ROLFING® PORTLAND OREGON, LLC

Please fill out this Insurance Intake & Verification form and return it to our office PRIOR to your initial session.

New Client Insurance Information

Patient Name:	Birth Date:	
Address:		
City:	State:	ZIP:
Primary Phone #:	Email:	

- For **Auto Insurance** please complete **PARTS 1**, **3** and **4**
- For **Health Insurance** please complete **PARTS 2, 3** and **4**

PART 1: Auto Insurance Info

Name of Insurance Co:	
Address:	
Contact person:	Phone:
Name of Insured:	Relation to patient:
Claim / Policy #:	Date of Injury:
Referring Physician:	Phone:
Attorney (if any):	Phone:

PART 2: Health Insurance Info

Name of Insurance Co:	
Address:	
Contact person:	Phone:
Name of Insured:	Relation to patient:
ID #:	Group No:

PART 3: Insurance Coverage Verification
Please contact your insurance company and verify your coverage by completing the following questions. This will aid our office in billing your insurance and give you a clear picture of what will be covered by your policy.

Name of Insurance Co:	
Spoke with:	Date of Contact:
Phone #:	Reference / Call #:

- Is Massage Therapy covered by this insurance policy? **Y / N**
    - Please note that Rolfing® is considered Massage Therapy in the State of Oregon. Many insurance companies will not know the term Rolfing® so it is often easier to just use the term Massage Therapy.
- Can a Licensed Massage Therapist (LMT) perform these services? **Y / N**
- Is there a Co-Pay for services provided? **Y / N**
- If YES how much is it?
- What percentage of billed charge is paid after co-pay?

- Is there a deductible that must be reached before payment is made? **Y / N**
- If YES how much?
- Has it been reached? **Y / N**
- Are the any limitations on coverage (dollar amount or number of visits)? **Y / N**
- If YES what are they?
- If this is for Health Insurance is a referral needed? **Y / N**
    - Please note that for Auto Insurance you MUST have a prescription for sessions from a Licensed Medical Provider.
- Is there a difference between In-network vs. Out-of-network coverage? **Y / N**
- If YES, is Rolfing® Portland Oregon, LLC in or out of network? **IN / OUT**
- What are submittal requirements for billing (mark all that apply):
    - HCFA: **Y / N**
    - SOAP notes: **Y / N**
    - Prescription: **Y / N**
- Where should these be sent?
    - Address:
    - Fax:

PART 4: Authorization
I authorize the release of medical records necessary to process this claim. I authorize payment by insurance company be made directly to the provider of services.

I understand the fees for services rendered will be billed directly 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**.

Print Name:	
Signature:	Date:

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Rolfing® Portland Oregon, LLC
5441 SE Belmont St. • Portland, OR 97215 • P: 503-280-5665 • F: 503-280-5665