Insurance Information

Insurance company: _____ Date of injury: _____

Billing address: _____ City_____ State_____ Zip_____

Adjuster's name: _____ Phone: _____

Member I.D.#: _____ Group #: _____

(Auto claim? Y/N Claim #: _____ Policy #: _____)

Primary insured person's name (your relationship: self/spouse/child/other):

Last name _____ First name _____ M.I. _____

Primary insured's date of birth _____ Primary insured's gender M/F

Primary insured's address _____

Primary insured's phone _____ Employer/school name _____

Referring physician _____ NPI # _____

Referral # _____ Phone # _____

Address _____City _____State _____ZIP _____

Attorney

Company _____ Lawyer _____ Ph _____

Address _____ City _____ State _____ Zip _____

- I will be ultimately responsible for payment of my bills.
- I will give 24 hour notice if I must cancel, or I will be charged the full price of the appointment.
- I authorize the release of any medical or other information necessary to process these claims.
- I authorize payment of medical benefits to Mark E. Hughes, L.M.P. for services billed.

Patient signature _____ Date _____

Mark E. Hughes, L.M.P
10508 Whitman Ave. N. #D, Seattle, WA 98133
(425)761-8321 mark@massage911.com