# Elite Muscular Therapy

210 West Evergreen, Suite 500
Vancouver, Wa. 98660
(360) 693-3863 (360) 693-6894 fax

## Confidential Insurance Information

Client name ______________________________ Date ____________________

Social Security # _________________________ Birth date ______________

Home phone _______________________ Work phone ____________________

Doctor's name _____________________ Doctor's phone _________________

(Please note: a doctor's prescription is always required for insurance billing)

Auto accident _____yes Insurance claim no. __________________________

Workman's comp _____yes Insurance claim no. __________________________

Health insurance _____yes Insurance Id. no. __________________________

For health insurance only: Insurance holder (if other than client)

Name ______________________ S.S.# ________________ Birth date __________

Street _______________________ City ____________ State ____ Zip _________

Home phone ____________________ Work phone ____________________

Name of insurance company ____________________________________________

Billing address _______________________________________________________

Name of agent handling claim _______________________ Phone _______________

### Office Use Only

Massage coverage ____yes ____no Co-pay amount $________

Rx needed: # of visits_____ # of times per week_____ #of weeks_____

Diagnosis codes: _______________________________________________________