**Confidential Client Intake Form CMS 1500-02/12**

Last Name(2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_\_

Address (5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_

SS# \_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_ Birthday (3)\_\_\_/\_\_\_/\_\_\_ Circle: M F

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prescribing Physician (17) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescribing Physician’s NPI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_

Status (8) Single \_\_\_\_\_ Married \_\_\_\_\_ Other \_\_\_\_\_

Employed \_\_\_\_\_ Full-Time Student \_\_\_\_\_ Part-Time Student \_\_\_\_\_

Condition Related to (10)a. Employment (Y) (N) b. Auto Accident (Y) (N) c. Other (Y) (N)

Insured's I.D. (if different from client) # (1a) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's Name (4) Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I. \_\_\_\_

Address (7) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_

Insured's Policy or Group Number (11) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured's D.O.B. (a) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Employer's Name (b) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Plan Name (c) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there another health benefit plan? (d) Y \_\_\_ N \_\_\_ (If yes, fill out below)

Other insured's name (9) Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_

Other Insured's policy or group # (a) \_\_\_\_\_\_\_\_ D.O.B. (b) \_\_\_/\_\_\_/\_\_\_\_Sex: M \_\_\_ F \_\_

Employer's Name (c) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance Plan Name (d) \_\_\_\_\_\_\_\_\_\_

The responsibility for the cost for each massage therapy session is the client's. Whatever portion of the session(s) not covered by a third party payer is the client’s responsibility. Release (12) : Authorized signature: I authorize the release of any medical or other information necessary to the medical treatment of my condition and to process this claim. I also request payment of medical benefits either to myself or to this medical provider.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_

Physician Diagnosis(21)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICD 9 \_\_\_\_\_\_\_\_\_