Katie Gavin, MSPT, LMT
Boulder Higher health
PHone: 720-772-8167
FAX: 713-913-0946

Date: ____/____/____

File #: _____

MEDPAY INTAKE FORM

PERSONAL INFORMATION

Full Name (last, first, initial): _____

Birthdate: ____/____/_____ Age:_____Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

Email: _____

INSURANCE INFORMATION

Insurance Provider: _____Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Claim Number: _____ Policy (Group #): _____

Policyholder Details: Only complete if is someone other than you

Name: _____ Birthdate: ____/____/_____ Sex: ☐ Male ☐ Female

Address: _____

ADJUSTER INFORMATION

Please supply as many contact details for the adjuster as possible.

Adjuster's Address: _____ Adjuster'sPhone: _____

Adjuster's Direct Fax: _____ Adjuster's Email Address: _____

VISIT INFORMATION

Date of MVA (motor vehicle accident): ____/____/_____

Who referred you to massage?: _____Their phone number:_____

Do you have a Rx from the referral source? ☐ Yes ☐ No *Please bring with you if you do.*

Did you go to the hospital or doctor after your accident? ☐ Yes ☐ No

Did you have a X-ray, MRI, or CT Scan? ☐ Yes ☐ No

Do you see chiropractic, physical therapist, or acupuncturist for this injury? ☐ Yes ☐ No

Provide name & contact info below:

_____

CONSENT & Authorization

I, (your name)_____, give my consent for my therapist, Katie Gavin, to communicate about my personal medical information or discuss my injury and status with the provided insurance adjuster, doctor and/or referring provider (chiropractor, PT or acupuncturist).

I, (your name) _____, authorize the release of any medical or other information necessary to process this claim between my therapist, Katie Gavin and my insurance carrier.

Signature: _____ Date: ____/____/_____