Michelle Pitman, LMT LLC
MichellePitmanLMT@gmail.com
945 Town Centre Drive, Suite A Medford, Oregon 97504
PH: (541) 286-8431 FX: (541) 690-1222

Insurance Intake Form

Thank you for your interest in using your insurance benefits with us. For insurance paid treatments, we will need a prescription from your doctor. To verify your benefits please complete the first section of this form. You can fax, email, or bring a copy to our office. Once we have received your completed insurance packet and a prescription, we will verify your benefits and then contact you to book your first appointment.

Section 1

Name:_____

Date of birth:_____ Phone Number:_____

Address:_____

Referring Doctor:_____ Phone Number:_____

Address:_____

Health Insurance Information:
Insurance company name:_____

Member ID:_____

Group number:_____

Insurance company contact number on the back of card: _____

Name of insured if other than yourself:_____

MVA or Workers Compensation Claims Insurance Information:
Insurance company name:_____

Claim Number:_____Adjuster's Name:_____

Adjuster's Number: _____Date of Accident:_____

Section 2: For Internal Use Only

Health Insurance Verification

Is the provider in network (Y/N):_____
Is the client covered for massage by a licensed massage therapist?_____
Does the client need a prescription or referral for massage?_____
What is the co-pay amount?_____
How many visits per year is the client allowed?_____
How many visits have been used?_____
Are the visits shared with other types of practitioners?_____
Is there a deductible?_____
Has it been met?_____
What is the renewal date for the insurance plan?_____
Does this client's plan require a pre-authorization?_____
If so how do you pre-authorize?
Pre-authorization number and information:_____

Reference # for the call _____

Name of the person you spoke to _____

MVA or Workers Comp Verification

Is the claim open and active? _____
Are there funds available? _____
Will the client be covered for massage by an LMT? _____
Will the client need a prescription? _____
What fax number do I send the claims to? _____

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HIPAA Privacy Rights

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. If services are paid in full by cash you may restrict that information to any insurer for purposes other than for treatment.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
You have a right to request that we amend your protected health information. Please be advised, however, that we may not be required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
You have a right to receive an accounting of disclosures of your protected health information made by Michelle Pitman, LMT LLC. You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Please note that this office submits insurance claims via electronic media and fax machine. If you are not comfortable with this, please notify us and we will use alternate methods.

Changes to this Notice of Privacy Practices

This office reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.
Complaints

Complaints about your privacy rights, or how Michelle Pitman, LMT LLC has handled your health information should be directed to Michelle Pitman by calling this office at (541) 286-8431. If Michelle Pitman is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.
If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights
200 Independence Avenue, S.W. Room 509F HHH Building Washington, DC 20201

FOR ADDITIONAL INFORMATION ABOUT YOUR PRIVACY, PLEASE VISIT:
www.hcfa.gov/medicaid/hipaa

Michelle Pitman, LMT LLC NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Michelle Pitman, LMT LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.
Disclosure of your Health Care Information Communication
We may communicate the following information through one or more of these methods: In person, by phone, by fax, by mail, or by email.

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. “It is our policy to provide a substitute health care provider, authorized by Michelle Pitman, LMT LLC, to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”
Payment We may disclose your health information to your insurance provider for the purpose of payment or health care operations. If payment is not made as arranged, our office may utilize an outside collection agency, credit reporting agency or other means of collecting outstanding debt. The designated collection agency or authority may review your file containing protected health care information.Workers’ Compensation If applicable, we may disclose your health information as necessary to comply with state Workers’ Compensation Laws. Emergencies We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.
Public Health As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.Judicial and Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.
Law Enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.Deceased Persons. We may disclose your health information to coroners or medical examiners Organ Donation & Research Though highly unlikely or probable we must inform you that there may a

need to release your health information to organizations involved in procuring, banking or transplanting organs and tissues, or to researchers conducting research that has been approved by an Institutional Review Board. Public Safety.It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.Specialized Government Agencies.We may disclose your health information for military, national security, prisoner and government benefits purposes.Marketing & Other Communication We may contact you for marketing purposes or fundraising purposes, as described below: (example)
“As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No protected health information will be disclosed during this call other than the date and time of your scheduled appointment and a request to call our office if you need to cancel or reschedule your appointment.” Please sign and date below to agree that you have read and understand your rights:

Your signature_____

Date Signed_____

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FINANCIAL AGREEMENT HEALTH INSURANCE

We would like to take a moment to welcome you to our office and to assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

EXPLANATION OF INSURANCE COVERAGE

Some insurance policies cover Massage and/or Acupuncture, but this office makes no representation that your policy does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for Massage and/or Acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance company(ies) in a timely manner. In the case that your insurance denies payment we will notify you via email and we will charge the credit card on file on a date that we have agreed upon after all efforts by our staff and yourself to collect payments have been exhausted.

PAYMENT AGREEMENTS

We require that you pay your copay on the day the services are performed. Any unpaid balance will be considered past due after 30 days and may incur a late fee.

ASSIGNMENT OF BENEFITS

Attached is an “Assignment of Benefits” form which we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office within 30 days upon receipt.

RELEASE OF INFORMATION

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and agree to the above and I authorize payment for only the items outlined above via the following credit/debit card:

Credit card number, exp. date, security code:

_____

Your signature:_____

Date signed:_____

Assignment of Benefits Provider information
(where payment is to be sent)
Facility/agency or provider name: Michelle Pitman, LMT LLC
Federal Employer Identification number: 83-1522057
Payment address: 945 Town Centre Drive, Suite A City: Medford, Oregon 97504
Phone number: (541) 286-8431

Assignment of Benefits
You authorize payment to be paid to the provider shown above for insurance benefits otherwise payable to me. Insurance payments are normally made within 120 days, if we have not received payment within that time frame and all of our combined available efforts to obtain payments have been exhausted you understand that you are financially responsible to the named provider for the charges.
I certify that the information furnished in support of this claim is true and correct and I authorize payments to made directly to (practice name).

Signature:_____
(the insured's or the insured's legal representative) (Required)

Date signed:_____