P. Leilani Berry, Licensed Massage Practitioner
(206) 248-2001 Fax (206) 431-5428
POB 88798, Tukwila, WA 98138
www.leilanimassage.com email : leilani@leilanimassage.com

Provider Name : P. Leilani Berry, LMP

BILLING INFORMATION

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Patient Information

Address _____
City _____ State _____ Zip _____
Phone: Home _____
Work _____ Cell/Pgr _____
Date of Birth _____
☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Partnered
Relationship of Patient to Insured:
☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other
Employed ☐ Student ☐ Part-time ☐ Full-time
Employer's Name or School Name:
_____
Phone _____ Fax _____
Is patient's condition related to:
Employment ☐ Yes ☐ No
Auto Accident ☐ Yes ☐ No
If Auto Accident, in what state? _____
Other Accident ☐ Yes ☐ No
Illness ☐ Yes ☐ No

Primary Health Care Provider

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

Attorney

Has an attorney been consulted? ☐ Yes ☐ No
Retained? ☐ Yes ☐ No
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

B. Insured (if other than patient)

Name _____
Insurance ID# _____
Date of Birth _____
☐ Male ☐ Female
Address _____
City _____ State _____ Zip _____
Phone: Home _____
Work _____ Cell/Pgr _____
Employer's Name or School Name:
_____
Phone _____ Fax _____

C. Primary Insurance Coverage

Insurance Carrier _____
Contact _____
Group Number _____
Plan # or Name _____
Billing Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

D. Secondary Insurance Coverage

Insured _____
Insurance ID# _____
Date of Birth _____
☐ Male ☐ Female
Address _____
City _____ State _____ Zip _____
Phone: Home _____
Work _____ Cell/Pgr _____
Employer's Name or School Name:
_____
Phone _____ Fax _____
Insurance Carrier _____
Contact _____
Group Number _____
Plan # or Name _____
Billing Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

E. Assignment of Benefits

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.

F. Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

G. Financial Responsibility

It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. If you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balance will be waived.

Signature _____ Date _____