Relaxation Works
Wellness Center and Spa
1253 Broadway (Rte. 138), Unit 1 • Raynham, MA 02767
774.226.8651 • relaxation-works.com

Patient Information To Verify Insurance (Injury Intake Form)
Fax 774-409-2072

Last Name:_____First Name:_____

Address:_____Apt:_____

Town:_____St:_____Zip:_____

Phone:C_____H_____W_____

SS#:_____ Marital Status:_____

Name Of Current Place Of Employment. (needed for billing purposes):

_____

Emergency Contact Name & Number:_____

Date of Birth:_____

Insurance Company Name:_____

Policy Number:_____

Claim Number:_____

Name of Adjuster:_____

Phone of Adjuster:_____ext:_____

Address of Insurance company:_____

State:_____Zip code:_____

Date of Accident:_____

Insurance Company Fax #:_____

Internal Use Only

Policy Limit:_____Policy Amount Left:_____

Today's Date:_____

Code Number/s:_____

Claim rep sent written confirmation to OK this claim:

Name_____Date:_____

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To be filled out by the physician. Fax 774-409-2072

Manual Therapist

PRESCRIPTION

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

A. Diagnosis

(Include ICD-9 codes that specifically address Manual Therapy Treatment)

_____

_____

_____

_____

B. Frequency & Duration

- ☐ 1× wk for _____ wks
- ☐ 2× wk for _____ wks
- ☐ 3× wk for _____ wks
- ☐ 2× month for _____ months
- ☐ 1× month for _____ months

C. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Primary & Secondary)

- ☐ Head _____
- ☐ Neck _____
- ☐ Chest _____
- ☐ Shoulders _____
- ☐ Abdomen _____
- ☐ Back _____
- ☐ Lowback/Hips _____
- ☐ Upper extremities _____
- ☐ Lower extremities _____
- ☐ All of the above _____
- ☐ Other: _____

Treatment Goals

- ☐ Decrease Pain
- ☐ Decrease Inflammation
- ☐ Decrease Muscle Tension/Spasms
- ☐ Decrease Compensatory Patterns
- ☐ Increase Mobility
- ☐ Increase Strength
- ☐ Restore Function
- ☐ Restore Posture
- ☐ Patient Education
- ☐ All of the Above
- ☐ Other _____

Specific Instructions/Precautions:

_____

_____

_____

_____

D. Referring Health Care Provider (HCP)

Contact Information

HCP Name _____

Address _____

City _____ State ____ Zip _____

Phone _____

Fax _____

Email _____

NPI # _____

Reporting—I will send an initial report after the first visit and a progress report after every 6–8 sessions. Please check how you would like to receive this information:

☐ Fax ☐ Mail ☐ Email

☐ Send Copies of Chart Notes with each report

HCP Signature: _____ Date _____

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To Be Given To Your Physician, Doctor or Nurse Practitioner

Relaxation Works is an Auto Injury Provider for patients seeking manual therapeutic massage therapy due to an injury related to their car accident. We have been providing this service since 2009, specifically working with physicians and insurance companies.

Your patient has inquired about receiving therapeutic services due to the car accident they were in. As a professional provider for auto injury, we require our prescription form to be filled out in completion (which we provided for you) so we can provide the needed information to the insurance company.

We are available for questions by contacting us at 774-226-8651.

Conditions that we work with specifically are whiplash, migraines, upper back, shoulder, neck and low back pain. In addition we work with less common but just as important pain conditions that include the forearm, hand, biceps injuries (usually due to the patient's hand hitting the steering wheel or window) and knee and leg injuries.

Kristen Sparks

Kristen Sparks
Relaxation Works
Owner
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