

**Insurance Intake Form
Sue Vittner Massage
31 Exchange St. Portland, ME 04101**

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| Name: | |
| Date of birth: | |
| Subscriber Name: (if not yourself) | |
| Subscriber Date of Birth: (if not yourself) | |
| Insurance ID#: | |
| Group #: | |
| Home Address: | |
| Home telephone: | |
| Cell telephone: | |
| Email: | |
| Employer(s): | |
| Marital Status: | |
| Secondary Health Insurance? (if yes, include insurance company name, ID#, Group #, and place of employment) | |

Medical and Payment Authorization

I authorize the release of any medical records necessary to process the above claims for services rendered to me by the above provider. I realize that if for any reason these services are not covered by the insurances listed above, I am fully liable for any unpaid services.

Signature of patient: _____
Date: _____

I authorize payment of benefits to be released directly to the above provider. I realize that if for any reason these services are not covered by the insurance listed above, I am fully liable for any unpaid services.

Signature of patient: _____
Date: _____