CLIENT & ACCIDENT INFORMATION

Client Name (Last, First) ____________________ **Date of Birth** ____________________

Address ____________________

City __________ **State** __________ **Zip** __________ **Phone** __________

Injury / Accident Date ____________________ **Claim Number** ____________________

Referring Provider ____________________ **Referring Provider Phone** ____________________

INSURANCE & POLICYHOLDER INFORMATION

POLICYHOLDER

☐ Policyholder name same as client

Policy Holder Name (Last, First) ____________________ **Policy Holder Number** ____________________

☐ Policyholder address same as client

Policy Holder Address ____________________

City __________ **State** __________ **Zip** __________ **Employer** __________

INSURANCE COMPANY

Insurance Company Name ____________________

Billing Address ____________________ **Phone** __________ **Fax** __________

Member / Policy ID # ____________________ **Group Number** ____________________

INSURANCE ADJUSTER

Adjuster Name ____________________ **Direct Phone** __________ **Adjuster Fax** __________

Adjuster Email ____________________

ATTORNEY (IF APPLICABLE)

Attorney Name ____________________ **Direct Phone** __________ **Attorney Email** __________

Law Firm ____________________

FOR OFFICE USE ONLY Verified by: ______________________ Date: ________________ Chart #: ________________

Notice of Privacy Practices

As required by the Health Insurance Portability and Accountability Act (HIPAA)

How We Use Your Information

Metamorphosis Neurofascial Therapy uses your health information for treatment, billing, and internal operations — including submitting insurance claims for your MVA, coordinating care with your referring provider, and quality review.

Disclosures Permitted by Law

We may disclose your information as required by law, for public health reporting, in response to court orders, to prevent a serious health or safety threat, and for MVA insurance or workers' compensation purposes.

Disclosures Requiring Your Authorization

Any use not described above requires your written consent. You may revoke authorization in writing at any time.

Your Rights

You have the right to inspect and copy your records; request corrections; request restrictions on use of your information; request confidential communications; and receive a paper copy of this Notice at any time.

Our Obligation

We are required to protect your health information and follow the terms of this Notice. Updates will be posted in our office and available on request.

Complaints

To file a complaint, contact our Privacy Officer or the U.S. Dept. of Health & Human Services, Office for Civil Rights: 1-877-696-6775 | www.hhs.gov/ocr. You will not be penalized for filing a complaint.

Acknowledgment of Receipt

By signing below, I acknowledge that I have received or been offered a copy of Metamorphosis Neurofascial Therapy’s Notice of Privacy Practices.

Patient / Guardian Signature	Date

Printed Name	Date of Birth

Authorization to Bill Insurance

Motor Vehicle Accident — Massage / Neurofascial Therapy

I, the undersigned, hereby authorize Metamorphosis Neurofascial Therapy to:

- Release any medical records, treatment notes, or health information necessary to process my insurance claim arising from my motor vehicle accident.
- Submit claims on my behalf to my insurance carrier and any applicable PIP (Personal Injury Protection) or MedPay coverage.
- Receive payment directly from my insurer (Assignment of Benefits). I understand my insurer will pay Metamorphosis Neurofascial Therapy directly rather than reimbursing me.
- Appeal any denial or respond to requests for additional information related to my claim.

By signing below, I confirm the information on this form is accurate and authorize Metamorphosis Neurofascial Therapy to bill my insurance as described above.

Patient / Guardian Signature	**Date**
Printed Name	**Date of Birth**

If patient is a minor, a parent or legal guardian must sign.

Informed Consent for Treatment

Services Provided

Metamorphosis Neurofascial Therapy provides massage therapy, manual therapy and neurofascial bodywork. Treatment involves hands-on contact, including tissue manipulation, fascial glides and mobilization.

Benefits & Risks

Massage therapy may reduce pain, muscle tension, and improve mobility. Possible side effects include temporary soreness, bruising, or a brief increase in symptoms. Please inform your therapist immediately if you experience discomfort during a session.

Contraindications

Inform your therapist if you have fractures, blood clots, active infection, unhealed wounds, severe osteoporosis, or are pregnant. You are responsible for disclosing any conditions that may affect your safety.

Scope of Practice

Your therapist is licensed by the Oregon Board of Massage Therapists and does not diagnose medical conditions or prescribe treatment. Massage therapy is complementary care and does not replace your physician or other medical providers.

Your Rights

You may decline or stop any technique at any time without affecting your care. Professional draping is maintained throughout every session.

I have read and understand the above. I consent to receive treatment at Metamorphosis Neurofascial Therapy and understand my right to ask questions or withdraw consent at any time.

Patient / Guardian Signature	Date
Printed Name	Date of Birth

If patient is a minor, a parent or legal guardian must sign.

Liability & Hold Harmless Waiver

I understand that massage therapy and neurofascial bodywork involve physical contact and carry inherent risks. I am receiving treatment in connection with a motor vehicle accident and may have injuries — including undisclosed or undiagnosed conditions — that require additional care.

I confirm that I have disclosed all known conditions and medications to my therapist and agree to notify Metamorphosis Neurofascial Therapy promptly if I receive new diagnoses, imaging results, or physician instructions after signing this form.

I voluntarily assume the risks of treatment and hereby release and hold harmless Metamorphosis Neurofascial Therapy, its therapists, staff, and agents from any claims, losses, or damages arising from treatment — except in cases of gross negligence or willful misconduct.

I understand that Metamorphosis Neurofascial Therapy does not diagnose injuries, prescribe treatment, or provide medical advice. I am responsible for obtaining appropriate medical care and clearance when recommended by my therapist.

This waiver is governed by the laws of the State of Oregon.

__________ I have read and understand this waiver and sign it voluntarily.

__________ I have disclosed all known medical conditions relevant to my treatment.

Patient / Guardian Signature **Date**

Printed Name **Date of Birth**

If patient is a minor, a parent or legal guardian must sign.

Financial Responsibility & Lien Agreement

I understand and agree to the following regarding payment for services at Metamorphosis Neurofascial Therapy:

______ **Personal Responsibility:** I am personally responsible for all charges, regardless of the outcome of my insurance claim. Any amount not paid by my insurer is my responsibility.

______ **Insurance Non-Payment:** If my insurance carrier denies, reduces, or delays payment for any reason — including policy limits, claim disputes, or coverage exclusions — I agree to pay the outstanding balance directly.

______ **Lien on Settlement:** I hereby grant Metamorphosis Neurofascial Therapy a lien against any insurance settlement, judgment, or recovery related to my MVA claim, in the amount of all unpaid charges. If I have an attorney, I authorize them to honor this lien and pay Metamorphosis Neurofascial Therapy from any settlement prior to disbursement to me.

______ **Cancellation Policy:** Cancellations require at least 24 hours' notice. Late cancellations and no-shows will be charged a fee of $100. This fee is the patient's responsibility and cannot be billed to insurance.

Attorney Name & Phone (if applicable) ______________________ **Law Firm** ______________________

______________________ ______________________
Patient / Guardian Signature **Date**

______________________ ______________________
Printed Name **Date of Birth**

If patient is a minor, a parent or legal guardian must sign.

FOR OFFICE USE ONLY | Lien on File: ■ Yes ■ N/A Attorney Notified: ■ Yes ■ N/A Date: _______________