
Victoria L. Johnson, LMT
819 North 49th Street - Suite 225
Seattle WA 98103
206-321-4980

Insurance Information

CLIENT INFORMATION

Client Name _____

Date of Accident/Onset _____

Birthdate _____

SSN _____

REFERRING PHYSICIAN INFORMATION

Physician Name/Title _____

City/State/Zip _____

Address _____

Phone _____

INSURANCE INFORMATION

Insurance Plan/Name _____

Subscriber/Policy No. _____

Name of Insured _____

Group No. _____

Insurance Company Address _____

Copay Amount _____ Phone _____

City/State/Zip _____

Claim Agent _____

IF YOU ARE NOT THE PRIMARY INSURED, PROVIDE THE FOLLOWING:

Insured's Address _____

SSN _____

City/State/Zip _____

Birthdate _____

DEPARTMENT OF LABOR AND INDUSTRIES INFORMATION

Employer _____

Phone _____

Address _____

L&I Claim No. _____

City/State/Zip _____

ATTORNEY INFORMATION

Name _____

City/State/Zip _____

Address _____

Phone _____

I agree to the release of any medical information that my health insurance may need in order to process payment. I assign medical benefits to be paid to Victoria L. Johnson, L.M.T. In the event that my insurance coverage expires, I understand that I am personally responsible for all fees unless another arrangement has been made.

Signature _____

Date _____