



Serene Lake
3501 Shelby Rd Ste B
Lynnwood, WA 98087
425-745-9052

Serene
5521 186th PL SW
Lynnwood, WA 98037
425-776-3000

Serene View
4803 84th St SW
Mukilteo, WA 98275
425-290-6024

NEW PATIENT REGISTRATION
 PLEASE COMPLETE FRONT & BACK

PATIENT INFORMATION							
LAST NAME OF PATIENT		FIRST NAME		MI	MALE FEMALE		AGE
ADDRESS			CITY		STATE	ZIP CODE	
HOME PHONE ()	WORK/CELL PHONE ()	DATE OF BIRTH	SOCIAL SECURITY NO.		EMPLOYER		YEARS
EMPLOYER'S ADDRESS		CITY	STATE	ZIP CODE	WHO WILL BE PAYING THE BILL? SELF OTHER		MARRIED SINGLE
PARENT OR GUARDIAN INFORMATION							
LAST NAME OF RESPONSIBLE PARTY		FIRST NAME		MI	MALE FEMALE		
ADDRESS (SAME AS PATIENT)			CITY		STATE	ZIP CODE	
HOME PHONE ()	WORK/CELL PHONE ()	DATE OF BIRTH	SOCIAL SECURITY NO.		EMPLOYER		YEARS
EMPLOYER'S ADDRESS		CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT		
IN CASE OF EMERGENCY NOTIFY							
LAST NAME		FIRST NAME		PHONE ()		ADDRESS	
MEDICAL INSURANCE COMPANY INFORMATION							
NAME OF PRIMARY INSURANCE COMPANY				GROUP #		ID#	
ADDRESS			CITY			STATE	
ZIP				PHONE ()			
NAME & ADDRESS OF INSURED IF DIFFERENT FROM PATIENT (For L&I and Auto, Please fill out section on back)							
PATIENTS RELATIONSHIP TO INSURED SELF HUSBAND WIFE CHILD OTHER							
REASON FOR TODAY'S VISIT							
HOW DID YOU HEAR ABOUT OUR CLINIC							
<p align="center">PAYMENT OF BENEFITS</p> <p>I understand that Serene Massage Therapy will bill my insurance if I have provided adequate information (ID and Insurance card). I authorize payment of benefits by my insurance company directly to Serene Massage Therapy. I agree that after 60 days all balances due become my responsibility regardless of insurance coverage. I also agree that all charges not paid by my insurance company will be my responsibility.</p> <p align="center">Terms</p> <p>If no insurance coverage, full payment is required at time of service.</p> <p>There will be a rebilling fee on any balance over 30 days. The rebilling fee is 1% or a minimum of \$3.00 per month. There will be a \$35.00 charge on any checks returned by your bank.</p> <p align="center">No Show Policy</p> <p>A \$50.00 "No- Show" fee will be charged for failing to show up on time for a scheduled appointment without cancelling at least 24 hours in advance. Additionally, future appointments cannot be scheduled until the "No-Show" fee is paid.</p>				<p align="center">Medical Release Authorization</p> <p>Insured party or dependent patient, if not a minor, must sign for all claims.</p> <p>I authorize any insurance company, organization, employer, hospital, or health care provider to release any information requested with regard to processing my claim.</p> <p>I certify that the information I furnish is true and correct.</p> <p>I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.</p> <p>I authorize my massage therapist to speak and confer with all health care practitioners involved in my case/claim.</p>			

SIGNATURE _____ DATE ____ / ____ / ____

Please Continue to Back

MEDICAL INFORMATION

- checkbox first massage, high blood pressure, osteoporosis, pregnancy, varicose veins, sports injury, SLE, regular exercise/sports activity, other
checkbox heart ailment, neck/spine injury, cold/flu virus, phlebitis, acute/chronic pain, cancer, ulcerated colon
checkbox headaches, on daily medication, diabetes, scoliosis, arthritis, kidney ailment, skin disorder
checkbox contact lenses, high cholesterol, sciatica, AIDS, asthma/allergies, tendinitis

List any allergies you have. (Include food and medication).

List any surgeries, hospitalizations, or major injuries you have had. Include dates.

List any chronic medical conditions you presently have.

List any medications you are currently taking.

L&I and AUTO INSURANCE COMPANY INFORMATION

(No Personal Information)

Insurance Plan

Name of Policy Holder

Billing Address

City/State/Zip

Member ID# Group #

Claim # Date of Injury / / Adjuster