Dawn E. Larned, LMT #20637
5315 NE Rodney Ave
Portland, OR 97211
512.968.7577

BREATH+GRAVITY: MVA FORM

MOTOR VEHICLE ACCIDENT CLIENT INFORMATION

CLIENT'S NAME: _____
(as shown on insurance card) Last Name First Name Middle

DRIVER'S LICENSE #: _____

CLIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME/CELL PHONE: _____ WORK PHONE: _____

CLIENT'S EMPLOYER: _____TELEPHONE: _____

EMERGENCY CONTACT PERSON: _____TELEPHONE: _____

MVA CLAIM NUMBER: _____POLICY #: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY BILLING ADDRESS: _____

_____

CLAIM REP NAME: _____

PHONE: _____ FAX: _____

MAIN INSURED'S NAME (if diff. from Client) _____

INSURED'S EMPLOYER: _____ EMPLOYER'S TELEPHONE: _____

INSURED'S BIRTH DATE:_____RELATIONSHIP TO PATIENT: _____

DATE OF ACCIDENT: _____

REFERRING MEDICAL PROVIDER: _____

MEDICAL PROVIDER'S ADDRESS: _____

MEDICAL PROVIDER'S PHONE NUMBER: _____

BRIEF MOTOR VEHICLE ACCIDENT + INJURY DESCRIPTION:

_____

_____

_____

_____

_____

_____

_____

PLEASE REVIEW THE INFORMATION YOU HAVE PROVIDED TO ENSURE THE CORRECT DATA FOR YOUR CHART AND BILLING INFORMATION. PATIENTS ARE RESPONSIBLE FOR KEEPING THIS DATA UPDATED WITH EACH VISIT TO ENSURE TIMELY BILLING AND COLLECTIONS.

Insurance is considered a method of reimbursing the PATIENT for fees paid to the practitioner and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not covered or reimbursed by your insurance carrier.

BY SIGNING THIS INFORMATION FORM, I HAVE BEEN INFORMED THAT IT IS MY RESPONSIBILITY TO CONTACT MY INSURANCE CARRIER TO VERIFY THAT ANY AND ALL AUTHORIZATIONS HAVE BEEN OBTAINED PRIOR TO THIS VISIT. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL FOR ALL SERVICES RENDERED REGARDLESS OF INSURANCE. IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTION AND/OR SUIT, THE PRACTICE SHALL BE ENTITLED TO ATTORNEY FEES AND COSTS OF COLLECTION.

AUTHORIZATION OF INSURANCE BENEFITS: I AUTHORIZE INSURANCE PAYMENTS TO GO DIRECTLY TO DAWN E. LARNED, LMT #20637. IF PAYMENTS ARE DEFAULTED TO ME, I AGREE TO PAY DAWN E. LARNED, LMT, FOR ALL MEDICAL SERVICES PROVIDED. I AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO DETERMINE LIABILITY FOR AND TO OBTAIN REIMBURSEMENT OF ANY CLAIM. THIS ASSIGNMENT SHALL REMAIN IN EFFECT UNTIL REVOKED IN WRITING BY ME. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

SIGNATURE: _____ **DATE** _____

HIPAA Privacy Authorization Form Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization: I give Dawn E. Larned, LMT #20637 permission to share my health information. I authorize the release of medical records or other health information, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, healthcare providers, and insurance case managers, for medical treatment or consultation, billing or claims payment, or other purposes as I may direct

2. Effective Period: This authorization for release of information covers the period of healthcare from all past, present and future periods.

3. I understand that I have the right to revoke this authorization in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

CLIENT'S PRINTED NAME: _____

CLIENT'S SIGNATURE: _____ **DATE** _____