

**Mali Piottin, LMP**

6300 9<sup>th</sup> Avenue NE, suite 310  
Seattle, WA 98115

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**PATIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: Home: \_\_\_\_\_ Cell/Work: \_\_\_\_\_ e-mail: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Student: no \_\_\_ yes \_\_\_ full time \_\_\_ part-time \_\_\_  
Referring Physician: \_\_\_\_\_  
Address of Physician: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone of Physician: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_  
Claim #/or Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Adjuster: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ State where Injury Happened: \_\_\_\_\_  
Policy Holder: Self \_\_\_ Other \_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_ SS #: \_\_\_\_\_  
Co-payment Amount if applicable: \_\_\_\_\_ Has deductible been met for the current year?: \_\_\_\_\_

**ATTORNEY INFORMATION**

Firm: \_\_\_\_\_  
Attorney: \_\_\_\_\_ Paralegal: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

I understand that I am financially responsible for all charges and agree to pay for all services rendered by Mali Piottin, in the unfortunate event that my insurance company denies payment, or makes a partial payment.  
I authorize Mali Piottin to release all and any information necessary to process any claim, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, health care providers, and insurance case managers. I further authorize that payment(s) be made directly to Mali Piottin, LMP.

In fairness to all, I will give a 24hr notice of cancellation or I will be charged personally the full fee for each missed session.

**CONTRACT FOR CARE**

I will participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based upon the information provided by my massage therapist. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of her skill and knowledge.

**SIGNATURE:** \_\_\_\_\_  
(if client is a minor, signature of parent or legal guardian)

**DATE:** \_\_\_\_\_