



Jessica Malabanan, LMT #16232  
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Health Insurance Form

Full Legal Name \_\_\_\_\_ Birthday \_\_\_\_\_

Gender:  Male  Female

Marital Status:  Married  Single  Separated  Divorced  Widowed

Employment Status:  Full-Time  Part-Time  Retired  Not Employed

Employer \_\_\_\_\_

Company Phone \_\_\_\_\_

Student Status:  Full-Time  Part-Time

Referring Physician's Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_

Insured's ID \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Birthday \_\_\_\_\_

Client's Relationship to Insured:  Self  Spouse  Child  Other

Insured's Employer \_\_\_\_\_

Insurance Plan or Program Name \_\_\_\_\_

By signing below, I give Jessica Malabanan, LMT #16232, of *The Tao of Touch* permission to communicate with the physician stated above to coordinate treatment. I also give *The Tao of Touch* permission to contact my insurance company to receive payment for services. I understand that I am responsible for co-pays and any balance due after insurance has paid for services.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Insured's signature \_\_\_\_\_ Date \_\_\_\_\_