

PERSONAL CONTACT INFORMATION

Name: _____ Age: _____ Date of Birth: _____
Street Address: _____ Home phone: (_____) _____
City: _____ Cell phone: (_____) _____
State / Zip: _____ E-Mail Address: _____
Employer: _____ Work Phone: (_____) _____
Referred By: _____ Emergency Contact: _____
Personal Physician: _____ Emergency Contact #: (_____) _____

MASSAGE HISTORY / PREFERENCES

Have you received professional massage before? Yes No If yes, date of last massage: _____
What results do you want from your session(s)? _____
What areas would you like prioritized? _____

MEDICAL HISTORY

Major Illnesses, accidents and/or injuries: _____

Please check any of the following that may apply: Wear contact lenses Communicable Illness
 Pregnant or trying to become pregnant Infection or inflammation Allergies to oils or lotions

Check any of the following conditions that you are experiencing, or have experienced in the past:

	Current	Past		Current	Past
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/ Lumbago/ Gout	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica/ Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>
Neck/ Spinal Injury	<input type="checkbox"/>	<input type="checkbox"/>	Migraines/ Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian/ Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/ Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis/ Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever/ Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Illness/ Pain	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia/ C.F.S.	<input type="checkbox"/>	<input type="checkbox"/>	Herpes/ Shingles	<input type="checkbox"/>	<input type="checkbox"/>
T.M.J./ Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Drug/ Alcohol Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine/ Nicotine Addiction	<input type="checkbox"/>	<input type="checkbox"/>

Please note any other medical condition that is affecting you: _____

Are you currently under the care of a physician for any of the above conditions? Yes No

Please list any medications you are taking: _____

PLEASE READ AND SIGN

I certify that the information provided above is true and accurate and that it is my choice to receive massage therapy. I agree to immediately notify my practitioner if any of the above listed conditions appear or change or if at any time the massage treatment causes any adverse physical reactions. I understand that massage practitioners do not diagnose illness or disease or any physical or mental disorders. I also acknowledge that massage is not a substitute for medical treatment, examination or diagnosis and that it is recommended that I see my primary health care provider for those services. I recognize that I am responsible for keeping my scheduled appointments and I agree to pay for the treatments at the time of service unless otherwise arranged in advance. I also understand that if I fail to keep my scheduled appointment I will be responsible for the cost of the therapist's time.

Signature

Date

INSURANCE PATIENT ADDENDUM

CLAIMS INFORMATION

L&I **Personal Injury (PIP)** **Health Insurance**

Please note: You may be uncertain as to how much information to provide here, if so just print out this section and bring it with you when you come in for your appointment, we can assist you with this when you come in.

Insurance Company: _____ Address: _____
Insurance Co. Phone #: (____) _____ Adjuster: _____ Extension #: _____
Policy #: _____ Group #: _____ Claim #: _____
Third Party Name: _____ Attorney Name: _____
Attorney Phone #: (____) _____ Referring Doctor: _____

DEFERRED PAYMENT POLICY

When appropriate we are happy to bill your insurance carrier for your convenience. However, although we are willing to assist in expediting payment, you are ultimately responsible for the cost of our services. Therefore it is understood that the deferring of payment, whether by special arrangement or for the processing of an insurance claim, is an EXTENSION OF CREDIT to you. Accounts left unpaid for 60 days or more may be subject to a 1.5% monthly finance charge.

WORKMAN'S COMPENSATION (L&I)

We bill directly to the Department of Labor & Industries or your private carrier if applicable. If your claim has not yet been accepted, we can still begin massage treatment for up to six visits. However, if the claim is rejected you are responsible for payment. If the claim is accepted we must establish that the treatment we are providing is improving your condition before additional treatment may be approved. Because of this, the determination for additional care is the responsibility of the referring physician and must be authorized by the Department of Labor & Industries.

PERSONAL INJURY / VEHICLE COLLISION CLAIMS (PIP & THIRD PARTY)

If available, we require that the Personal Injury Protection (PIP) feature of your auto insurance coverage be accessed for payment when a motor vehicle collision is responsible for your injury. In essence, we will bill your auto insurance carrier (whether you were at fault or not) for payment of your medical bill. When your claim is resolved with the other party your insurance company will determine the at fault party and if the other party is determined to be responsible his or her insurance company will reimburse your company for the costs associated with your treatment. Your coverage and standing are generally not affected by this process. If this feature has expired or is not available and this becomes a third party claim, there may be a fee charged directly to you for the filing of a lien against your claim to protect our interest in this matter. We may also require that you be represented by legal council in the event of a third party claim before accepting your case.

I have read and understand the above listed terms for my treatment and for the payment of services and agree to them in full. I also authorize the release of any and all medical information necessary for the processing of these claims and the payment of benefits directly to the treating practitioner.

Signature

Date