MASSAGE REGISTRATION AND HISTORY

Patient Registration Form

Patient Name:_____ Date of Birth:_____

Home Phone:_____ Cell:_____ Work:_____

Email Address:_____

Street Address:_____ City, State, Zip:_____

Please present your insurance card and ID for scanning

Insurance Carrier:_____ Phone Number:_____

Subscriber:_____ Date of Birth:_____

Relationship to Subscriber: Self Spouse Dependent

ID or Claim Number:_____ Group Number:_____

Claims Address:_____

For L&I and Auto injury, please specify date of accident:_____

Please read the following carefully before signing:

I, the undersigned, understand that payment is expected in full at the time of service, including all copay amounts for insurance billing. I authorize the treatment of the person named above to agree to pay all fees for such treatment. I hereby authorize my health care practitioner(s) to receive all benefits to which I and/or my dependents are entitled under my health insurance plan. In addition, I will not withhold or delay payment if my insurance company denies payment of any of my charges. I have also been informed of the $50.00 fee (per RCW 62A, 3-515 & 520) on all checks returned by my bank NSF.

I, the undersigned, agree that I am obligated to pay for this account. Should the balance of this account exceed an amount I am able to pay in full within 30 days, a 1% per month re-billing fee will be applies (per RCW 19.52) unless a mutually satisfying solution is agreed upon by both the undersigned and my health care practitioner(s).

Signature:_____ **Date:_____**

MASSAGE REGISTRATION AND HISTORY

Name:_____ Date:_____

Occupation: _____ Referred By:_____

Have you ever have you ever had a professional massage before? ❑ YES ❑ NO

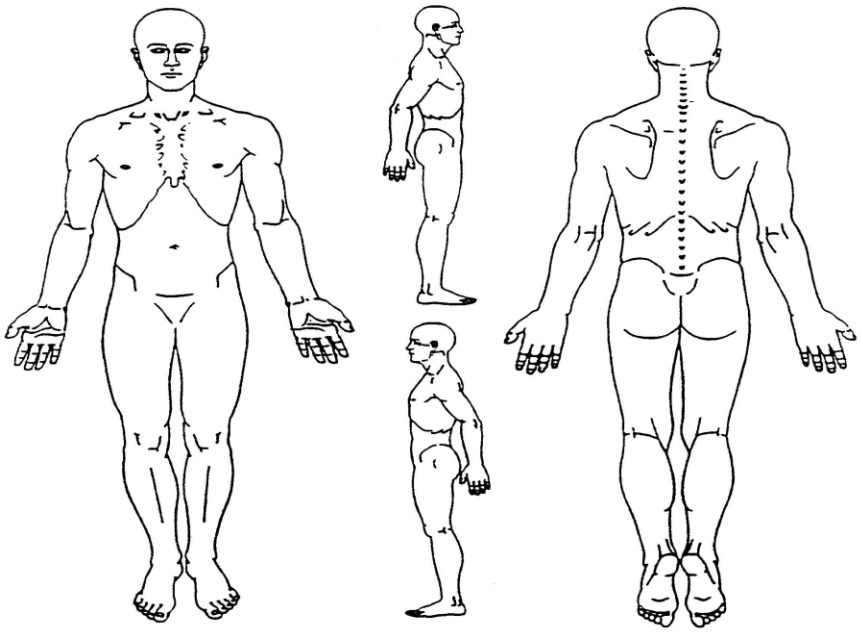
1. If yes, when was your last massage?
2. What did you especially like or dislike?
3. Type of massage experienced: ❑ Swedish ❑ Relaxation ❑ Shiatsu ❑ Deep Tissue ❑ Injury Treatment ❑ Other:

What are your goals/expectations for this massage session?

Do you exercise regularly? ❑ YES ❑ NO. If yes, how often and what type of exercise?

Do you prefer during your massage visit: ❑ No talking ❑ Don't mind a little talking

Please circle any areas you are experiencing pain tension or discomfort. Please mark with an (X), if any, the areas in which you don't want to be touched:



Do you have any problematic areas that you need more focus on?

Where do you hold stress in your body?

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Have you ever experience any of the following? Please use 'C' for current, 'P' for past, 'S' for sometimes:

__ HIV/AIDS	__ Constipation	__ Herpes	__ Sciatica
__ Allergies	__ Diarrhea	__ High/ Low Blood Pressure	__ Stiff Joints
__ Abdominal Pain	__ Diabetes	__ Lymphedema	__ Skin Allergies
__ Athletes Foot	__ Digestive Problems	__ Insomnia	__ Sprains/Strains
__ Arthritis	__ Disc Problems	__ Excess Stress	__ Stroke
__ Back Pain	__ Diverticulitis	__ Migraines	__ Swollen Feet/Legs
__ Bone Fractures	__ Eczema	__ Muscle Spasms	__ Tendonitis
__ Bursitis	__ Epilepsy/Seizures	__ Numbness	__ Tingling
__ Cancer	__ Fibromyalgia	__ Phlebitis	__ Tumors
__ Chronic Fatigue	__ Headaches	__ Psoriasis	__ Varicose Veins
__ Circulatory Problems	__ Heart Attack/Ailments	__ Rashes	__ Whiplash
__ Colitis	__ Hemophilia	__ Other _____	

For women: __ Pregnant __ Trying to be pregnant __ Menstrual Cramps

If you are pregnant, how many weeks are you and expected due date?

Are you currently under the care of a physician? ❑ YES ❑ NO

Are you currently receiving chiropractic care or physical therapy? ❑ YES ❑ NO
If yes, please explain

Are you taking any medications (prescription & over the counter) ❑ YES ❑ NO
If yes, please explain:

Accidents, Injuries or Surgeries-
Less than 5 years ago:
More than 5 years ago:

Please read and sign the following:
I acknowledge that the above information is complete and accurate to the best of my knowledge and that I will notify the massage therapist of any changes in my health or physical condition. I understand that a massage practitioner cannot diagnose. It is recommended that I see a health care provider for one or any health related questions that I many have.

Signature: _____ Date: _____

Appointment Cancellations and Financial Policies

Your massage practitioner is pleased that you have decided to include massage therapy as part of your health plan. It is important that you understand the following policy:

Cancellation and No Show Fees:
- Appointments are made in advance to accommodate your schedule. If you are unable to keep an appointment, notification is required **at least 24 hours in advance** so that another patient has the opportunity to take that appointment.
- Upon the missed appointment you will receive a bill for $85.00

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Financial Policy:
All patient balances are due at the time of service. This includes all deductibles, co-pays/co-insurance and cash balances.

Prices:
Massage therapy is billed at $175.00. If you don't have insurance or elect to not use those benefits the prices are as follows for payment on the same day of service:

- 60 Minute Massage $85.00
- 90 Minute Massage $120.00

Two times per year, we also offer a special price for a 5-package massage purchased in advance. Prepay four hours and get the fifth hour free. Total charge for this is $320.00.

Prescriptions and Referrals:
Our office does require that the patient have a valid prescription or referral in order to bill insurances for massage therapy. If you do not have a valid prescription or referral at the time of service, payment will be required at that time. You will be reimbursed upon receipt of a valid prescription or referral.

Please read and sign the following:
I will not withhold or delay payment if my insurance company denies payment for any of my charges. I will pay for the massage visit if I do not have a prescription for the massage if my insurance company requires one at the time of service.

I have read the above and understand and agree to abide by these policies:

Guardian/Client Signature:_____ Date:_____

Privacy Practice Acknowledgement

I have been notified of the Privacy Practice and have received the Notice of Privacy Practices upon my request and/or I have been provided an opportunity to review it.

Name:_____

Signature:_____ Date:_____