Massage Intake Form

Leah Maier, LMT
10224 SW Park Way, Suite A
Portland, Or 97225

Personal Information

Name: _____ Phone (day): (___)_____ evening: (___)_____
Address: _____ City/State/Zip: _____ DOB: __/__/____
Occupation: _____ Employer: _____
Email: _____ Primary Physician: _____
Emergency Contact: _____ Relationship: _____ Phone: (___)_____
How did you hear about us? _____

Medical Information

Are you taking any medications? ☐No ☐Yes
if yes, please list name and use
_____

Are you currently pregnant? ☐No ☐Yes
if yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐No ☐Yes
if yes, please explain _____

what makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? ☐No ☐Yes
if yes, please list:
_____
_____

Have you had any auto accident injuries? ☐No ☐Yes
if yes, please explain:
_____
_____

Please check any of the following that apply to you.
☐Cancer
☐Arthritis
☐Diabetes
☐Joint Replacement(s)
☐High/Low Blood Pressure
☐Neuropathy
☐Fibromyalgia
☐Stroke
☐Heart Attack
☐Kidney Dysfunction
☐Blood Clots
☐Numbness
☐Sprains or Strains

Explain any condition you have marked above:
_____
_____
_____

Massage Information

Have you had a professional massage before? ☐No ☐Yes

What type of massage are you seeking?
□ Relaxation □ Therapeutic/Deep Tissue
Other _____

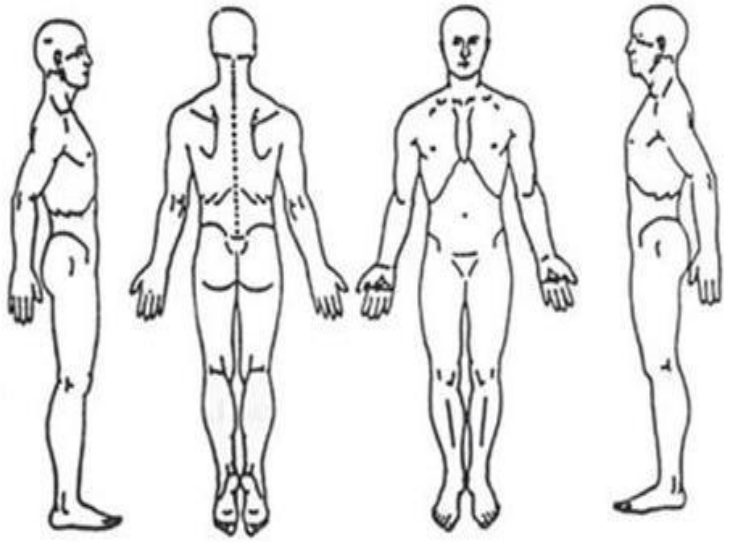
What pressure do you prefer?
□ Light □ Medium □ Deep

Do you have any allergies or sensitivities? ☐No ☐Yes
Please explain _____

Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ No ☐ Yes
Please explain _____

What are your goals for this treatment session?
_____

Please circle any areas of discomfort.



By signing below you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Leah Maier, LMT
10224 SW Park Way, Suite A Portland, OR 97225 ph: 503.297.1174 fax: 503.297.2623

FINANCIAL RESPONSIBILITY AGREEMENT

Policy:

1. All patients not covered by insurance must pay at time of service.
2. All co-pays, deductibles, and balances will be collected at the time of service.
3. In those cases where your insurance company denies payment, you are responsible for costs incurred. Payment is expected before the end of the billing month.
4. Any balances due to Total Health Wellness Center Providers after your Insurance carrier has notified the Clinic of payment or non-payment will be billed to you.

After thirty (30) days of the first bill, a finance charge of $2.50 per month will begin to apply to your account. Any bill over ninety (90) days past due will be subject to collection procedures.

If you need to make payment arrangements, you can do so by contacting our Billing office. Once you agree to a payment plan, you will sign on your agreement. All payment agreements must be followed through within the allotted timeline.

We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic.

I, _____ (patient's name or name of parent/legal guardian or responsible/legal party) as a patient of Total Health Wellness Center, acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

_____
Signature of Patient or Parent/Legal Guardian/Responsible Party

_____
Patient's Printed Name

Date _____

RECORDS RELEASE *(Please read and sign)*

I hereby authorize the release of any medical or other information necessary to process my claim for medical benefits. I authorize my Insurance Company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____ _____
Patient or Parent/Legal Guardian for patient under 18 years of age Date

_____ _____
Witness's Signature Date

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Acknowledgement of receipt of Notice of Patient Privacy Practices

I have received the NOTICE OF PATIENT PRIVACY PRACTICES, which describes how The Providers and Representatives of **Total Health Wellness Center** may use and disclose my protected health care information to carry out treatment, payment of services, health care operations and other purposes that are allowed by law. This notice also describes my patient rights and the requirements of **Total Health Wellness Center** to protect my health information.

Total Health Wellness Center reserves the right to change the privacy practices that are described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time and discuss its content with the Privacy Officer.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Description of Personal Representative's Authority**

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Authorization & Consent to Examine & Treat

To Whom It May Concern:

I hereby authorize the Providers of Total Health Wellness Center to administer all Medical examination procedures as deemed necessary. I have reported all health conditions that I am aware of and will inform my Practitioner of any changes in my health.

_____ _____

Patient signature Date

Our Cancellation Policy

Since your appointment time is important and reserved especially for you, we ask that you please call AS SOON AS POSSIBLE, preferably 24 hours in advance, to make any changes to it. This allows us to offer that time to another patient who needs care.

We reserve the right to charge a Missed Appointment Fee of $55.00 to those patients who miss their appointment without notifying us, or who repeatedly cancel with less than 24 hours notice.

We value your business and strive to ensure that we are always available to you, as well as the rest of our patients, when you need us.

Thank you.

I understand and agree to the above:

Patient Signature: _____ **Date:** _____