

MASSAGE INTAKE FORM

6700 15TH Ave NW • Seattle, WA 98117 • (206) 784-3494

Today's Date: _____ Name: _____ M F

Address: _____ Birth Date: _____ Age: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Who may we thank for referring you? _____

Insurance Company: _____

Insurance billing will be handled out of this office. If you have an insurance card, please let us know and we will see that your insurance company receives the proper information to process your claims. For worker's injuries an Accident Form must be completed. Motor vehicle accident cases will be discussed in depth due to the complexity of such cases. An auto accident questionnaire must also be completed. We look forward to serving you!

TODAY'S ISSUES

Primary area of concern: _____

Date of onset: _____ Cause, if known: _____

Other Health Care Providers seen for condition: _____

HEALTH HISTORY

Any accidents, injuries or surgeries: Yes No

More than 5 years ago: _____

Less than 5 years ago: _____

Are you currently receiving medical treatment or are you under a doctor's care? Yes No

If yes, please explain: _____

Are you taking any medications? Yes No

If yes, please explain: _____

Are you currently experiencing any of the following condition?

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Infection/Inflammation | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Aneurysms | <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Herniated Discs | <input type="checkbox"/> Tumors | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Ring Worm | <input type="checkbox"/> Varicose Veins |

Comments: _____

MASSAGE HISTORY

Have you received massage before? Yes No Date of last massage: _____

Do you have a preference of a massage style, any likes or dislikes?

How often and in what way do you exercise?

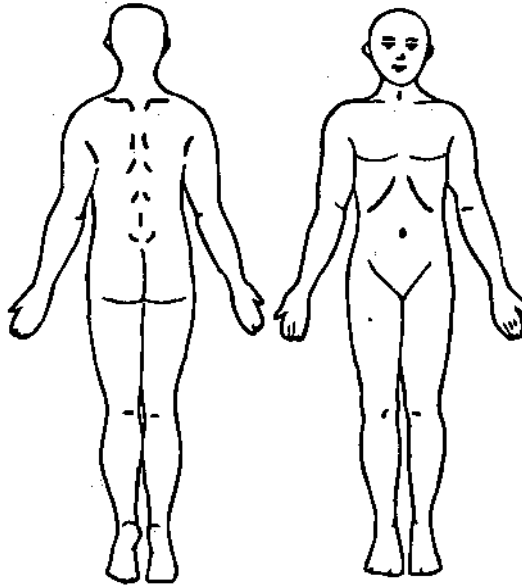
Where do you tend to hold stress in your body?

What areas do you want to assure are addressed today?

Are there any areas we need to avoid or that are especially sensitive to touch?

Do you wear contact lenses? Yes No

**Please mark any problem
areas on the diagrams
to the right**



I understand that massage practitioners do not diagnose illness or disease, prescribe any medical treatment, pharmaceuticals, or perform manipulations. I understand massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a Physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that a service charge of 1% per month may be added to accounts 30 days past due. Should legal action be required to collect my account, I agree to pay such sums as the court may adjudge reasonable as attorney's fees, together with all costs and expenses of such suit. I authorize my therapist to speak with my referring health care provider regarding my care. I understand that I will be charged a \$25.00 fee for any returned checks.

I agree to the policy that the fee for services may be charged in the event of cancellation with less than 24 hours notice. I agree to update my practitioner of any changes in my health status.

Client's Signature: _____ **Date:** _____

MASSAGE THERAPY CANCELLATION POLICY

- Please give 24-hour notice if you need to cancel your appointment.
- If you do not give us notification to cancel your appointment, we may be unable to fill that time slot with other patient's needing care. Out of consideration for others, please call to cancel your appointment if you can not make it.
- **\$35.00** will be charged for missed appointment without 24-hours notice. However, this charge will be waived should your time slot later be filled.
- Insurance companies do not cover missed appointments and it is illegal for us to bill them for appointments the client did not receive.

Your signature below indicates you agree and will abide by this clinic policy.

Client Signature: _____ Date: _____

Wellness for Life Chiropractic

6700 15th Ave NW
Seattle, WA 98117
206-784-3494

Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved, in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Practice Practices containing a more complete description of the uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship if other than patient: _____

Date: _____

FOR OFFICE STAFF ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____

Reason: _____

Name: _____

Notice of Privacy Practices

This notice describes how medical information about you may be used, disclosed and how you can get access to this information.

Please review it carefully

The Health Insurance Portability and Accountability Act of 1996 HIPAA is a Federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form; whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may disclose your medical record only for each of the following purposes: **Treatment, payment and health care operations.**

- **Treatment** means providing coordinating or managing health care and related services by one or more health care providers. Examples of this would include your primary care physician, physical or massage therapist, etc.
- **Payment** means such activities as obtaining reimbursement for services, confirming converge, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be internal quality assessment review.

We may also create and distribute the identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer to be forwarded to medical records.

- The right to request restrictions on certain uses and disclosures of protected health information including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in affect. We reserve the rights to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised *Notice of Privacy Practices* from this office.

You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights about violations of the provisions of this notice. We will not retaliate against you for filing a complaint.

Please feel free to contact us for more information.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services

Office of Civil Rights

200 Independence Avenue SW

Washington, DC 20201

(202) 619-0257 Toll Free; (877) 696-6775