MassageWorks – Patient Information

Personal Information

Name ______________________________________Date of Birth _______________ Age ______ Sex ☐Male ☐Female
Address _____________________________________ City ____________________State _________Zip _____________
Home Phone ____________________ Cell Phone ___________________ Email ______________________________
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Emergency Contact ______________________________________ Phone _______________________________

Employment Information

Employment Status ☐ Employed ☐ Retired ☐ Student ☐ Does Not Apply
Employer __________________________________ Occupation ________________ Work Phone _________________

Primary Insurance Holder Information (If applicable)

Name _______________________________________ Date of Birth_________________ SSN# ______ - _____ - ______
Home Phone ___________________________ Cell Phone ____________________ Relationship ___________________
Employer ____

Secondary Insurance Holder Information (If applicable)

Name _______________________________________ Date of Birth_________________ SSN# ______ - _____ - ______
Home Phone ___________________________ Cell Phone ____________________ Relationship ___________________
Employer ____

Are you seeking treatment due to a new or previous ☐On-the-Job Injury ☐Auto Accident ☐Does Not Apply

If yes, date of accident ______________ Ins Co Name_________________________ Claim/Policy _________________

Name of Claims Manager/Adjuster ____________________________________ Phone ___________________________

Address _____________________________________ City ____________________State _________ Zip ____________

Do you have an attorney? ☐Yes ☐No Attorney's Name ________________________________ Phone _________________

(***Please read carefully, initial, and sign below***)

I understand that **24-hour notice is required to cancel or reschedule appointments**. If I am unable to keep a scheduled appointment I will, to the best of my ability, provide 24 hours notice. I understand that I may be charged a $35 fee for missed or cancelled appointments with less than 24 hours notice given. ______

Delinquent accounts (90 days past due) may be assigned to a collection agency. All collection cost will be added to your outstanding balance and will become an additional cost to you. MassageWorks will not be held responsible for any collection agency's fees. ______

____ _________________________

Patient (or parent if minor child), or other legally authorized person Date

MassageWorks – Health History

Patient Name____
Have you experienced a professional massage before? ☐Yes ☐No If yes, how recently___________________________________
Are you receiving other therapies? ☐Yes ☐No If yes, what kinds? ____
Are you/could you be pregnant? ☐Yes ☐No if yes How many weeks/months______________ Delivery Date ______________
Have you ever been hospitalized or required surgery____
Please explain

Medications you are taking (Check all that Apply)

☐Steroids ☐Anti-inflammatory ☐Pain Killers ☐Heart or Blood Pressure ☐Anti-coagulants (blood thinners) ☐Muscle Relaxants

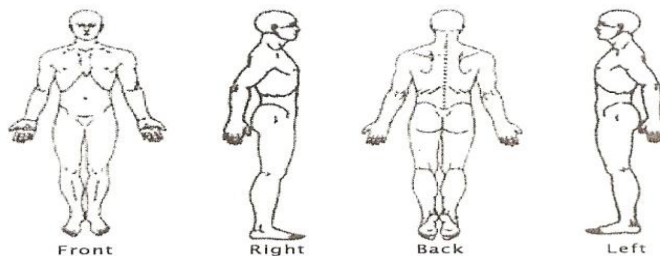
☐Insulin Other Medications or Supplements____

Please circle if you are currently experiencing or have recently had any of the following

Chest Pain	Tuberculosis	Muscle Spasm	Contagious Disease	Stress
Heart Attack	Joint Problems	Muscle Tension	Skin Problem	Anxiety
High Blood Pressure	Bursitis	Inflammation	Open Sores/Wounds	Insomnia
Low Blood Pressure	Osteoporosis	Chronic Pain	Cancer	Fatigue
Pacemaker	Arthritis	Headache/Migraines	Tumors	Depression
Stroke	Sciatica	Dizziness/Vertigo	Hepatitis	Fever
Seizure	Sprain/Strain	Kidney Problems	HIV/Aids	
Diabetes	Back Pain	Varicose Veins	Other Medical Conditions______________________	
Lung Disease	Neck Pain	Edema	____	
Asthma	Fibromyalgia	Poor Circulation	____	
			____	

Reason for your visit today?______________________________________ When did your symptoms first appear?______________
Are your symptoms getting progressively worse? ☐Yes ☐No What symptoms are you experiencing ☐Sharp ☐Dull ☐Aching
☐Throbbing ☐Burning ☐Tingling ☐Numbness ☐Cramping ☐Shooting ☐Stiffness ☐Tension ☐Spasm ☐Swelling
☐Other ____
How many days a week do you experience these symptoms?______ Are your symptoms ☐Constant ☐Intermittent ☐Frequent
Do your symptoms interfere with ☐Work ☐Sleep ☐Daily Routine ☐Recreations ☐Other ________________________________
What makes your symptoms worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Walking ☐Other__________________________
Home remedies you have tried ☐Ice ☐Heat ☐Stretching ☐Medications ☐Other____

On the diagram mark the locations of your symptoms



Circle the severity of your pain on a 0 (no pain) to 10 (severe pain)

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

Average Pain: 0 1 2 3 4 5 6 7 8 9 10

CONSENT FOR TREATMENT (*Please read carefully and sign below*)

I understand that massage practitioners do not diagnose illness, disease, physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. I understand that massage is not a substitute for a medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. It is my choice to receive massage therapy, and I give my consent to receive treatment. I have stated all my known medical conditions that I am aware of and I will inform my massage practitioner of any changes in my health.

____ ____________________________
Patient (or parent if minor child), or other legally authorized person Date

MassageWorks Policies

Our patient's are important to us and our appointment times are limited. If you are unable to keep your appointment please notify our office as soon as possible, we may be able to fill your appointment time with a patient on our waiting list. 24 hour notice is required for changes to your appointment. Less than 24 hours notice or a no show to your appointment may result in you being charged a $35 fee. These fees are not covered by insurance and failure to pay these fees may result in your account being assigned to a collection agency.

Financial Policies

The following are financial policies for massage therapy in our office. Check the box next to the policy you wish to use. Please be sure to read carefully and make sure you understand and agree to the policy prior to signing this document.

[ ] **CASH PATIENT**: Payment is required at time of service. We accept cash, checks, Visa, Mastercard, and Discover. (*Any returned check will result in a $35 NSF fee. All future appointments will require cash or credit card payment.)*

I certify that I am a cash patient and responsible for all fees for service. I understand that payment is required at time of service.

____ ____________________

Patient (or parent if minor child), or other legally authorized person Date

PLEASE NOTE If you are using any of the following policies for payment of services, you MAY be required to have a referral or prescription for massage therapy from your primary physician, chiropractor, or other qualified healthcare provider. Check with your insurance company to determine if this is a requirement prior to treatment at MassageWorks. A qualified staff member at MassageWorks can contact your insurance company, on your behalf, and provide you with a quote of benefits. However, these quoted benefits are not a guarantee of paid services until your insurance company has officially processed your claim. Delinquent accounts (90 days past due) may be assigned to a collection agency.

[ ] **HEALTH INSURANCE**: Every insurance policy is different and it is up to you to know beforehand exactly what your benefits are and what the requirements are for having your claims accepted. We will gladly submit medical claims to your insurance company, but there is no guarantee your policy will cover and pay for massage therapy. **You are liable for claims rejected by your insurance company and any amounts not paid.** Co-payments, coinsurance, and deductibles are due at the time of service.

[ ] **WORKER'S COMPENSATION** (L&I): All on the job injuries ***MUST BE REPORTED TO YOUR EMPLOYER AND A CLAIM MUST BE FILED*** with the Department of Labor & Industries, or your employer's self insured firm. If you were injured on the job, you will need to have a referral and your claims adjuster must approve massage. If your claim is denied, or massage treatments not allowed, you will be responsible for the payment of services received.

MOTOR VEHICHLE ACCIDENTS

[ ] **PERSONAL INJURY PROTECTION**: If you were involved in a motor vehicle accident, your auto insurance policy may pay for your treatment. Your treating physician(s) must authorize treatment and provide a written referral. If your personal injury policy does not cover your treatment, your policy limits are exhausted, or your carrier has suspended benefits, your claim will revert to a Third Party Claim or No Insurance status.

[ ] **THIRD PARTY CLAIMS**: In the event you do not have Personal Injury Protection under your auto insurance policy, arrangements can be made to hold your bill until the time of settlement with the third party carrier. In order to receive treatment under a third party claim, your treating physician(s) must authorize treatment and provide a written referral. MassageWorks may recommend that you obtain legal representation from an attorney, as you may be required to sign a third party attorney's lien. An auditor's lien may be filed against your claim with the Pierce County Auditor's office.

I certify that I have insurance coverage as marked above and assign all insurance benefit payments directly to MassageWorks. **I understand that I am financially responsible for any and all charges not paid by my insurance for any reason.** I herby authorize MassageWorks to release all information necessary, including medical records, to secure the payment of benefits.

____ ______________________

Patient (or parent if minor child), or other legally authorized person Date

MassageWorks

HIPPA Communication Request

Patient Name ____ Date ______________________

Massageworks patients may be contacted via email and/or text messaging to remind you of an appointment and/or to provide general health reminders/information.

______ (Patient initials) I consent to receive text messages and email, regarding appointment reminders from Massageworks, at the cell phone number and email provide below.

Cell Phone ____

Email____

MassageWorks uses Fullslate (an online scheduling program). Your email and cell phone number is used **ONLY for confirmation and information related to appointments, specials, and office closures.**

I understand that MassageWorks **cannot** release my account information/balance or appointment information **to anyone** but me without a valid release of information signed by me.

I understand that changes may be made to the above listed and my request and will remain in effect until such time as a new communication request form is submitted by me to MassageWorks.

At my request I will be provided with a copy of MassageWorks privacy notices and practices which describes how my health information is used and shared. I understand that I have the right to request restrictions on uses and disclosures of my health information for treatment, payment, and all other health care operations. Such restrictions must be submitted to MassageWorks in writing.

____ ____________________________

Patient Signature (or parent if minor child), or other legally authorized person Date

MassageWorks

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

WE HAVE A LEGAL DUTY TO PROTECT HEATLH INFORMATION ABOUT YOU

We are required to protect the privacy of health information about you and any information that can be identified with you. Each time you visit our clinic for treatment, a record of your visit is made. Typically, this record contains your symptoms, treatment, and a plan for future care and treatment. This notice describes the types of uses and disclosures of your health information that we may make and gives you examples.

YOUR HEALTH INFORMATION RIGHTS

Although your health record is the physical property of MassageWorks, the information belongs to you. You have the right to:

Request a restriction on certain uses and disclosures of your information
We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. Limited use and disclosure without your authorization is permitted in circumstances where there is an overriding public interest, including: disclosures for public health activities, health oversight activities and other governmental functions, medical research, to report abuse, neglect, in an emergency situation, and for judicial and law enforcement purposes.

Inspect and copy your health record
Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the record, we may give you a summary or explanation of your health information about you. There are certain situations in which we are not required to comply with your request. Under these circumstances we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

Amend your health record
You have a right to request that we make amendments to clinical, billing, and other records used to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: 1.) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2.) the information is not part of the records used to make decisions about you; 3.) we believe the information is correct and complete; 4.) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing of the reasons for denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received health information about you and who need the amendment.

Obtain an accounting of certain disclosures that are made of your health information
You can request and accounting of disclosures by submitting a request in writing. Limited use and disclosure without authorization is permitted in circumstances where there is an overriding public interest, including disclosures for public health activities and other governmental functions, medical research, to report abuse and neglect, and for judicial and law enforcement purposes.

Request communications of your health information by alternative means or alternative locations
You have the right to request how and where we contact you about protected health information. For example, you many request that we contact you at your work address or phone number or by email. Your request must be in writing. We must accommodate reasonable requests, but, when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternate address or other method of contact.

Revoke your authorization to use or disclose health information except to the extent that action has already been taken

MASSAGEWORKS DUTIES

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties & privacy practices with respect to information we collect and maintain about you
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations
- Abide by the terms of this notice

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH OPERATIONS

We will use health information for treatment.
For example: Information obtained by a massage therapist, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. We will also provide your referring physician or subsequent health care provider with copies of various reports that should assist him or her in treating you once you are discharged from the clinic.

We will use your health information for payment.
For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, dates of service, as well as your diagnosis, any supplies used, and treatment summaries.

We will use your health information for regular health operations.
For example: Members of the business administration staff may use information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare services we provide.

OTHER USES AND DISCLOSURES

Appointment Reminders: We may contact you to provide appointment reminders.
Information about our Services: We may contact you with information about treatment, services, products, or health care providers that may be of interest to you.
Notifications: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care your location, and your physical condition.
Communication with Family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
Government Oversight and Related Agencies: We may disclose health information to the extent necessary to comply with laws relating to worker' compensation or other similar programs established by law; to public health or legal authorities charged with preventing or controlling disease, injury, or disability; for law enforcement purposes as required by law, or in response to valid subpoena; to the FDA, health information relative to adverse events with respect to food, supplements, product or product defects or post marketing surveillance information to enable product recalls, repairs, or replacement. Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority, or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.
You may object to such uses and disclosures in writing, except in cases where MassageWorks is required to abide by the law

ANY OTHER USE OR DISLOSURE OF PERSONAL HEALTH INFORMATION ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION

Under any circumstances other than those listed above, we will ask for your written authorization before we use or disclose personal health information about you. If you sign a written authorization allowing us to disclose personal health information about you in a specific situation, you can later cancel your authorization in writing. If you cancel your authorization in writing, we will not disclose personal health information about you after we receive your cancellation, except for disclosures which were being processed before we received your cancellation.

If you have questions or would like additional information, or if you believe your privacy rights have been violated by the unauthorized and/or improper use and disclosure of your health information and would like to file a complaint you may send your written questions or complaint to the United States Secretary of the Department of Health and Human Services. All complaints will be investigated and appropriate corrective actions taken to ensure that we are in compliance with privacy regulations. If you file a complaint, we will not take any action against you or change or treatments for you in any way.

ACKNOWLEDGEMENT OF PRIVACY NOTICE

I understand that MassageWorks is a health care provider and that it will use or disclose my health information for treatment, billing, and healthcare operations. At my request, I can be provided a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand that I have the right to request restrictions on uses and disclosures of my health information for treatment, payment, and health care operations purposes.

My signature constitutes my acknowledgement that I have read and understand the notice of privacy practices at MassageWorks .

____ ____________________________

Signature of patient (or parent of minor child) or other legal representative Date

____

If signed by a legal representative, relationship to patient

To be completed by MassageWorks personnel only

A good faith effort was made to obtain acknowledgement of receipt of the MassageWorks privacy policy by: ____

Patient Name

Acknowledgement was not received because ____

Explanation

____

Printed Name of Certifying Massage Therapist

____ ____________________________

Signature of Certifying Massage Therapist **Date**