APPLIED HEALTHCARE ASSOCIATES

Massage Therapy
Personal Record and Consent Form

☐ **Candice Copeland** ☐ **Tom Manson** ☐ **Jennifer Marion** ☐ **Charlie Wichser**

Name:_____ Referred by:_____

Occupation:_____ DOB:_____ SS#:_____

Address:_____ City/State/Zip:_____

Home#_____ Work#_____ Cell#_____

E Mail Address_____
Insurance Company:_____ ID#_____
Is this a car or work related accident? (circle one) Yes No
Date of Injury:_____ Date of last Massage:_____

TREATMENT INFORMATION

Are you currently seeing a medical practitioner? If yes please explain._____

_____

List current medications, including aspirin, ibuprofen, etc._____

_____

List any major accidents or surgeries:_____

_____

What results do you want from your massage session?_____

_____

HEALTH HISTORY

Musculo-Skeletal
_____bone disease
_____tendonitis
_____bursitis
_____arthritis
_____low back/hip/leg pain
_____neck/shoulder/arm pain
_____headaches
_____jaw pain
_____lupus
_____spasms/cramps
_____sprains/strains
_____other

Circulatory
_____heart condition
_____varicose veins
_____blood clots
_____high blood pressure
_____low blood pressure

Skin
_____allergies
_____rashes
_____athletes foot
_____warts
_____other

Digestive
_____constipation
_____gas/bloating
_____diverticulitis
_____irritable bowel
_____other

Reproductive
_____pregnant
_____PMS
_____other

Other
_____cancer/tumors
_____diabetes
_____eating disorder
_____depression
_____drug/alcohol addiction

Nervous
_____herpes
_____shingles
_____numbness
_____chronic pain
_____fatigue
_____sleep disorders

Please explain any conditions marked:_____
_____

INFORMED CONSENT

It is my choice to receive massage therapy. I realize treatment is being given for the well being of my mind and body. This includes stress reduction, relief from muscular tension/spasms/pain, and the increase of circulation or energy flow. I agree to communicate with my practitioner any time I feel my well being is being compromised.
I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.
I understand that I am responsible for all payments under any circumstances .
I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

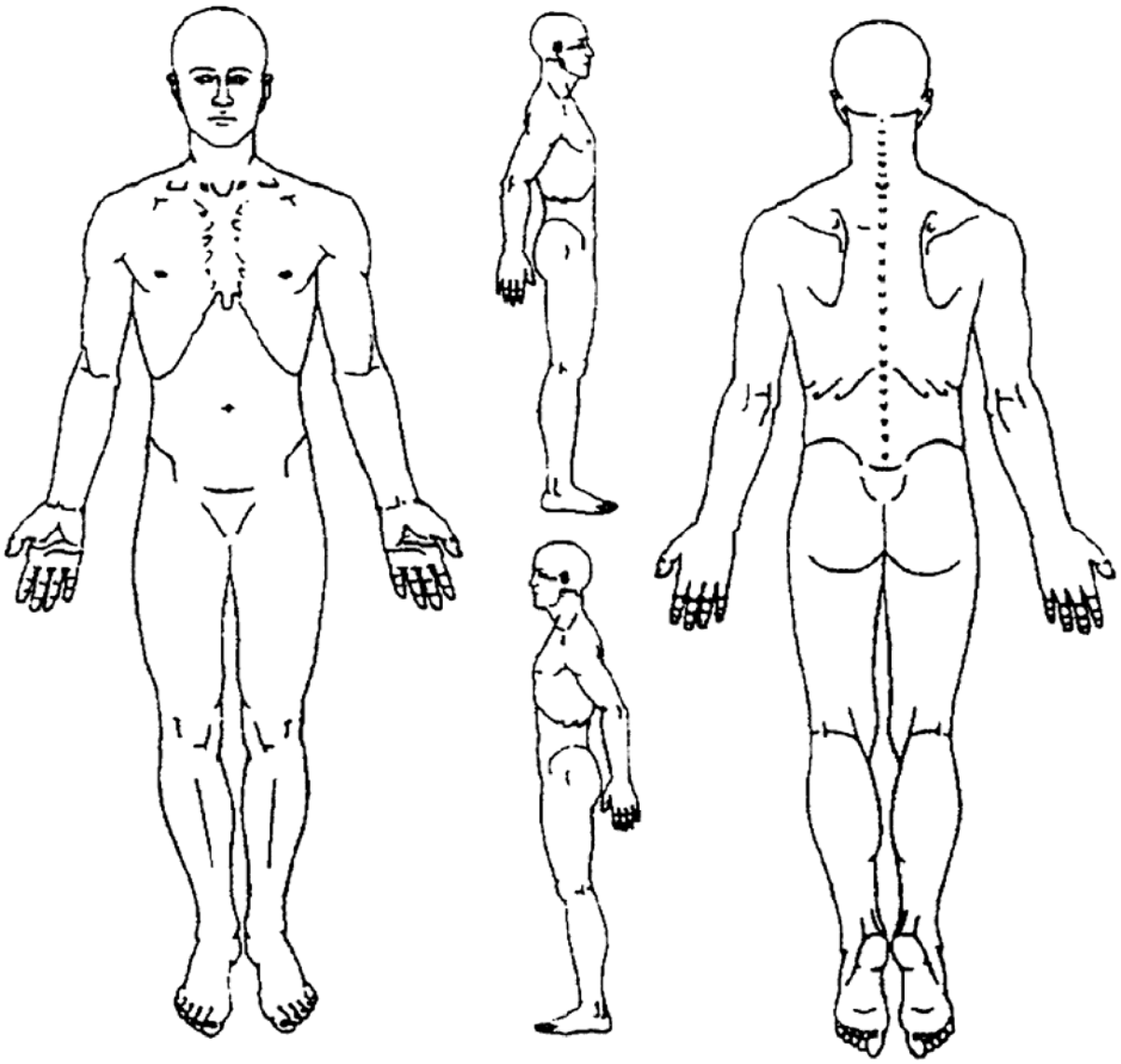
SIGNATURE:_____ **DATE:**_____

Massage Subjective Assessment

Please use the following symbols to accurately mark the areas in which you feel any of the described sensations. Include all affected areas.

Dull pain: N N N Stabbing/ Cutting: /// /// /// Burning: X X X

Numbness: = = = Tinging (Pins & Needles): ::: ::: ::: Cramping: S S S



Please place one mark on each line below to indicate your response:

1.What is your pain RIGHT NOW?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

2. What is your TYPICAL or AVERAGE pain?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

3. What is your pain at its WORST?

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain Ever

APPLIED HEALTHCARE
ASSOCIATES

FINANCIAL AGREEMENT

I agree to pay for these health care services:
(Please check the appropriate box)

□ With *cash, check, or credit card* at each office visit. There is a bookkeeping discount if paid at time of service.

□ With payments from my **health insurance** policy, plus any co-pay or deductibles that are my responsibility.

□ With payments from the **Department of Labor and Industries** (worker's compensation)

□ With payments from my **Personal Injury Protection** from my car insurance company or with proceeds from a legal settlement (plus interest) if this is from an automobile accident.

_____ _____
Signature of Responsible Party Date

Fees for services rendered at this office are the responsibility of the patient receiving the care or the designated responsible party. Amounts not covered or denied by the insurance company, L&I, or Medicare, are still the responsibility of the patient. This includes the insurance deductible (if applicable) and any remainders the insurance company does not pay. A minimum of $2.00 per month finance charge is included on all past due accounts, that is, thirty days after a balance accrued. As a service to the patient, we will bill the insurance company, but please keep in mind that insurance policies are agreements between the patient and the insurance company, not between the practice and the insurance company. We want your health expenditures to be minimal and appreciate your regular payments without our having to request them.

CANCELLATION POLICY

We require a 24-hour notice for all cancellations. If you do not show up for your scheduled appointment or fail to give proper notification for all cancellations you will be charged a $25.00 fee. Please note that your insurance company is not responsible for these charges. All changes are subject to the circumstances and are at the discretion of the provider.

_____ _____
Signature Date

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, _____ (Name of Individual) consent to Applied Healthcare Associates, P.S. ("the Practice's") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes.

Healthcare operation purposes shall include, but not be limited to quality assessment, activities, credentialing, business management, and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including: demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me; the past, present, or future payment for the provision of health care services to me; or Information that identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand that I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment payment or healthcare operations of the Practice, but the Practice is not requited to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

I understand that I have a right to review the Practice's Notice of Privacy Practices, prior to signing this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative Authority