Massage Intake Form

Personal Information

Name: _____ Phone #: _____
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 medication? Yes No
If yes, please list name and use: _____
_____
Are you currently pregnant? Yes No
- If yes, how far along? _____
- Any high risk factors? _____

Do you suffer from chronic pain: Yes No
- If yes, please explain: _____
- What makes it better? _____
- What makes it worse? _____

Have you had any orthopedic injuries? Yes No
- If yes, please list: _____

Please Check any of the following that apply to you.

__ Digestive Problems
__ Cancer
__ Migraines
__ Back Problems
__ Sciatica
__ Kidney/Bladder
__ Osteoporosis
__ Diabetes
__ Stoke
__ Hepatitis
__ Ulcers
__ Heart Problems
__ Allergies
__ Carpal Tunnel
__ Skin Problems
__ Hi/Low Blood Pressure
__ Elimination Problems
__ Tumors
__ Sinus Problems
__ Neck Problems
__ Arthritis/Bursitis
__ Aids/HIV
__ TMJ
__ Tendonitis
__ Anemia
__ Cold Hands/Feet
__ Bruise Easily
__ Fibromyalgia
__ Asthma

Massage History

Have you ever had a professional massage?
Yes No
If yes, how often: _____

Desire Pressure: __ Extra Light __Light
__Medium Firm __ Firm __Deep

Please check ALL areas of your body that you give permission to receive massage
__ Back __Legs __ Gluteals __ Arms
__ Abdomen __ Pecs/Chest __ Neck
__ Head __Feet __ Hands

Massage Information

What type of massage are you seeking?
__ Relaxation __Therapeutic/ Deep Tissue
Other: _____

Do you have any allergies or sensitivities to aromatherapy? Yes No
Please explain: _____
_____
_____
_____
_____
_____
_____
_____

By signing below, you agree to the following:

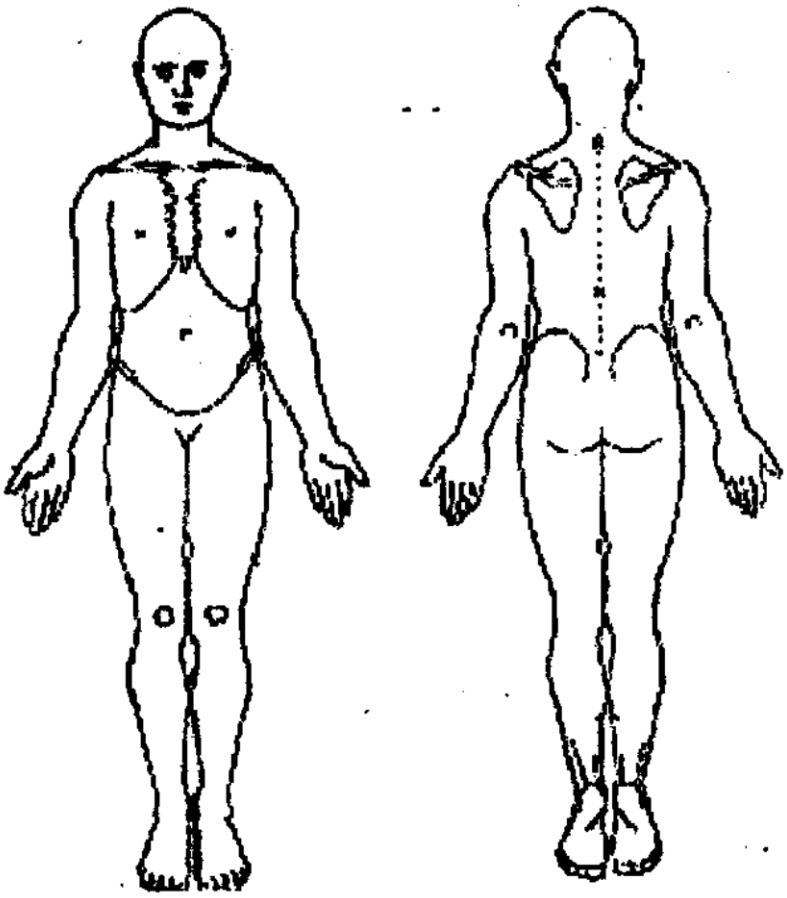
- I understand that massage therapy is provided for stress reduction, relaxation. Relief from muscular tension, and improvement of circulation.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/ stokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after my session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

Client Signature: _____ Date: _____
Therapist Signature: _____ Date: _____

Date:_____ Patient Name:_____

Please mark the diagram with “xx” where your pain typically presents:



On a scale of 1 to 10, (1 being minimal pain and 10 being excruciating), please rate your overall pain:

at worst: _____
at best: _____
on average: _____

Pritchette Physical Therapy
orthopedic & sports rehabilitation
aquatic therapy • sports performance

CLINIC AND PATIENT RESPONSIBILITIES & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IT IS THE PATIENT RESPONSIBILITY:

- Patients need to know and understand their insurance policy/policies. Patients should be aware of benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance and co-payments. If you are not familiar with your plan coverage, we recommend that you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial Responsibility of the patient.
- To pay the co-payment, deductibles, and coinsurance at the time of service.
- To notify Pritchette Physical Therapy of cancellations as soon as possible. If a cancellation is received less than 24 hours or you are a no show for a scheduled visit, Pritchette Physical Therapy reserves the right to charge you $25.00 for these types of cancellations and/or no show.

IT IS PRITCHETTE PHYSICAL THERAPY RESPONSIBILITY:

- To provide quality medical care.
- To file insurance claims for our patients. Claims are filed with insurance carriers no less than 3x/week.
- To send patient statements periodically during treatment and balance is due upon receipt of statements.

FINANCIAL POLICY ACKNOWLEDGEMENT AND ASSIGNMENT OF BENEFITS:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services that were rendered. If I receive insurance payments directly from my insurance, I will immediately sign over the check to Pritchette Physical Therapy.

My signature acknowledges receipt of HIPAA compliant Notice of Privacy Practices. I will receive a copy only when I request one.

Patient or Responsible Party Signature DATE

Printed Patient Name

4730 E. WARNER RD., SUITE 5 PHOENIX, AZ 85044 OFFICE: (480) 785-5415 OPTION 1 FAX: (480) 785-5761
1331 E. CHANDLER BLVD. SUITE 102 PHOENIX, AZ 85048 OFFICE: (480) 785-5415 OPTION 2 FAX: (480) 687-0467

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements Officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.com

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be sorted in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, U.S. mail or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of the both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy, I understand that this consent shall remain in force from this time forward.

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Massage Cancellation Policy Agreement

This Cancellation Policy Agreement (the "Agreement") is made between the Massage Therapist and the patient, or if the patient is a minor, between the Massage Therapist and the patients legal guardian or representative.

_____ (the "Patient")
Print Name

The massage Therapist understands that situations arise in which the Patient must cancel their massage therapy appointments. However, the Massage Therapists needs at least 24 hours' notice in order to adjust their schedule to avoid loss of their time and to fulfill their business obligations.

By signing this agreement and scheduling massage appointments with the Massage Therapist, the Patient agrees to provide the Massage therapist at least 24 hours' notice, from the time the scheduled massage therapy appointment is to begin, of any cancelations. The Patient may provide such notice to Massage Therapist by communication the Patient's intent to cancel the appointment directly to the Massage Therapist (by phone call, voicemail, or text message) or by calling Pritchette Physical Therapy at (480) 785-5415.

If the Patient fails to provide notice under this Agreement, the Patient shall pay the Massage Therapist a $65 cancellation fee. The Patient shall pay all cancellation fees in full before the Patent may schedule another massage therapy appointment with any other Massage Therapist at Pritchette Physical Therapy.

Please Sign that you have read/understand and agree to this Agreement.

_____ _____
Signature of Patient or Legal Guardian Date