

Massage Intake



Name: _____ Male Female Today's Date: _____

Date of Birth: ___/___/___ Age: _____ Height: _____ Weight: _____ SS # _____

Marital Status: Married Single Divorced Widowed Student Status: Full time Part Time Non-student

Race: American Indian or Alaska Native Asian Black Caucasian Pacific Islander Other Declined

Ethnicity: Hispanic Non-Hispanic Declined Preferred Language: _____

Home Address: _____
Street / P.O. Box City State Zip Code

E-Mail: _____ How did you hear about us? _____

Employment Status: Full Time Part Time Occupation: _____ Work Phone: _____

Are you: Working without restrictions Working With Restrictions Not working/ off since: _____

Home Phone: _____ Cell Phone: _____ Primary Care Doctor: _____

Are you seeing us for an injury from: Auto Work Sports Injury No Injury Other: _____

Emergency Contact: _____ Phone Number: _____ Relationship: _____

Insurance Information: Please bill: Auto Insurance Workman's Comp. Health Insurance Self Pay

General Consent Form: I understand that I am receiving a therapeutic massage intended to increase my quality of life. I agree to all treatments within the treatment parameters of the certified massage therapist. I will not hold the therapist or Scott Family Health* liable for any injuries, accidents, communication differences, conflicts, or physical ailments that may occur during or after treatments. I understand that the massage therapist does not diagnose and I am responsible for seeking care with any other health professionals for any concerns regarding a condition/ ailment or diagnosis. I agree to be responsible for all charges for services rendered. The information in my chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimal disclosure necessary as related to your care. Please see the Notice of Privacy Practices for more detailed information. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my massage therapy insurance benefits, including private insurance and other health plans to Scott Family Health. I understand that all plans are different and I may have one or more of the following that I am responsible for: deductible/ co-pays/ percentage owed for each date of service or no massage therapy benefits. When billing any workman's compensation claims or auto accident claims please note that *before treatment is rendered* all billing information including, but not limited to a claim number and the address of where the claims need to be sent must be presented at *the time of service*. When billing health insurance I understand that I must present my insurance card at the time of service. Scott Family Health has the right to not treat any patient if all required information is not provided. I understand that any accounts that are 90 days overdue are subject to collection proceedings, regardless of case type. Please be aware that a \$20.00 fee will be assessed for any check returned for non-sufficient funds. * **Payment for treatment is required at the time of service.**

Massage Therapy and Acupuncture: PLEASE NOTE: Most insurance companies do not cover massage therapy. We are willing to bill only *qualifying* health insurance plans for massage services. Massage charges are \$45.00 for a half hour and \$70.00 for an hour (subject to change).

Release of Records: I authorize Scott Family Health to release all health records necessary for my treatment and/or evaluation. I also authorize Scott Family Health to release any protected health information required to secure payment.

Cancellation policy: I understand that I will be responsible for an office visit of \$35.00 for an hour massage (subject to change) or \$22.50 for a half hour massage (subject to change) for failure to cancel or reschedule within 24 hours of my scheduled appointment. The massage schedule is very limited; therefore we strictly enforce this policy. Please also be aware that any patients arriving late for their scheduled appointment may be required to shorten their treatment time, wait until the next available opening, or reschedule their appointment and thus be subject to the above stated cancellation policy. Thank you for your cooperation.

Patient/ Responsible party's signature: _____ Date: ___/___/___
(if patient is under 18 years of age)

*Scott Family Health includes Dr. Trenton Scott, Dr. Gina Scott, Dr. Scott Hessler, Ashley Johnson, Michah Stephens, Tanya Hemberger, and Michelle Hykes.

What is your reason for getting massage? _____

Have you ever had a massage before? YES / NO If yes- when and with whom? _____

Were you referred by a doctor or other health care professional? YES / NO

If yes, by whom? _____

Name of primary care doctor: _____

List all medications that you are currently taking. _____

List all herbal or other supplements you are currently taking. _____

List any injuries in the past 5 years. _____

List any surgeries/ broken bones in the past 5 years. _____

WOMEN: Are you currently pregnant? YES / NO If yes, how many weeks? _____

Do you have a history of miscarriages? YES / NO

PLEASE CHECK ANY OF THE FOLLOWING THAT PERTAIN TO YOUR BODY AND HEALTH:

GENERAL:

- Sinus problems/ allergies
- Numbness/ Tingling
- Weakness
- Arthritis
- Seizures
- Fainting
- Dizziness
- Memory Loss
- Varicose Veins
- Diabetes
- Shortness of breath
- Heart problems
- Blood clots
- Lupus
- Multiple Sclerosis
- Skin conditions
- Pain with coughing/ sneezing
- Nausea
- Low back pain Mid back pain Neck pain
- Cancer
- Headaches
- High/Low Blood Pressure _____
- Ringing in ears

HIPS/ LEGS/ FEET:

- Leg/ foot cramps
- Swollen ankles
- Tingling/ burning
- Shooting pains
- Ticklish feet

ARMS/ HANDS:

- Weakness
- Clumsiness
- Shooting pains
- Tingling/ burning
- Swelling

NECK/ SHOULDERS:

- Stiffness
- Tightness
- Burning
- Decreased range of motion
- Shooting pains
- Popping/ clicking