Anchored Massage Therapy

Patient Intake Form

Patient Information:

Name:_____ Phone # (best to contact you at): (_____)_____

DOB: _____ Address: _____

City:_____ State (if not WA): _____ Zip Code:_____

Email: _____ Emergency Contact: _____

How did you hear about Anchored MT?:_____

***For every referral, you will receive a one-time extra 30 min massage add-on for free!

Insurance Information:

Health Ins. Carrier: _____ Primary Insured's Name:_____

Primary Insured's DOB: _____ Subscriber ID #: _____

Group #: _____Phone # (for provider's on the back of the card): (____)_____

Referring MD, DO, ND, PT, DC or ARNP: _____

***Please read and sign where needed for the following information very carefully. If you have any concerning conditions or symptoms massage/bodywork maybe contraindicated. A referral from your doctor may be required.

Have you received a massage before (circle one): Yes No How recently?: _____

What type of pressure do you prefer (circle one): Light ---------X---------Medium---------X---------Deep

General Health (Check any of the following that apply to you):

( ) Yes ( ) No Do you have a Fever?
( ) Yes ( ) No Do you have any contagious disease, including a cold or flu, even if mild?
( ) Yes ( ) No Are you under the influence of any drug or alcohol-including prescription pain medication?
( ) Yes ( ) No Do you have any skin disease?
( ) Yes ( ) No Do you have any Varicose Veins?
( ) Yes ( ) No Are you or may you be Pregnant?
( ) Yes ( ) No Do you have any cuts, bruises, abrasions, or sunburns?
( ) Yes ( ) No Do you have any Inflammation, including Arthritis?
( ) Yes ( ) No Do you have any cardio-vascular conditions (such as but not limited too thrombosis, phlebitis, hypertension, heart conditions)?
( ) Yes ( ) No Do you have Psoriasis or Eczema?
( ) Yes ( ) No Do you have High or Low Blood Pressure?
( ) Yes ( ) No Do you have Diabetes?
( ) Yes ( ) No Do you suffer from Seizures or Epilepsy?
( ) Yes ( ) No Do you suffer from stress?
( ) Yes ( ) No Do you suffer from Headaches and/or Migraines?
( ) Yes ( ) No Do you bruise easily?
( ) Yes ( ) No Did you have an injury or accident in last two years?
( ) Yes ( ) No Do you suffer from back pain?
( ) Yes ( ) No Do you have numbness or stabbing pain anywhere?
( ) Yes ( ) No Are you sensitive in any area to pressure or touch?
( ) Yes ( ) No Are you currently taking any medications and/or supplements?

***If you selected **YES** to any of the questions above please explain below. Use additional pages, if necessary.

_____

_____

_____

_____

Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

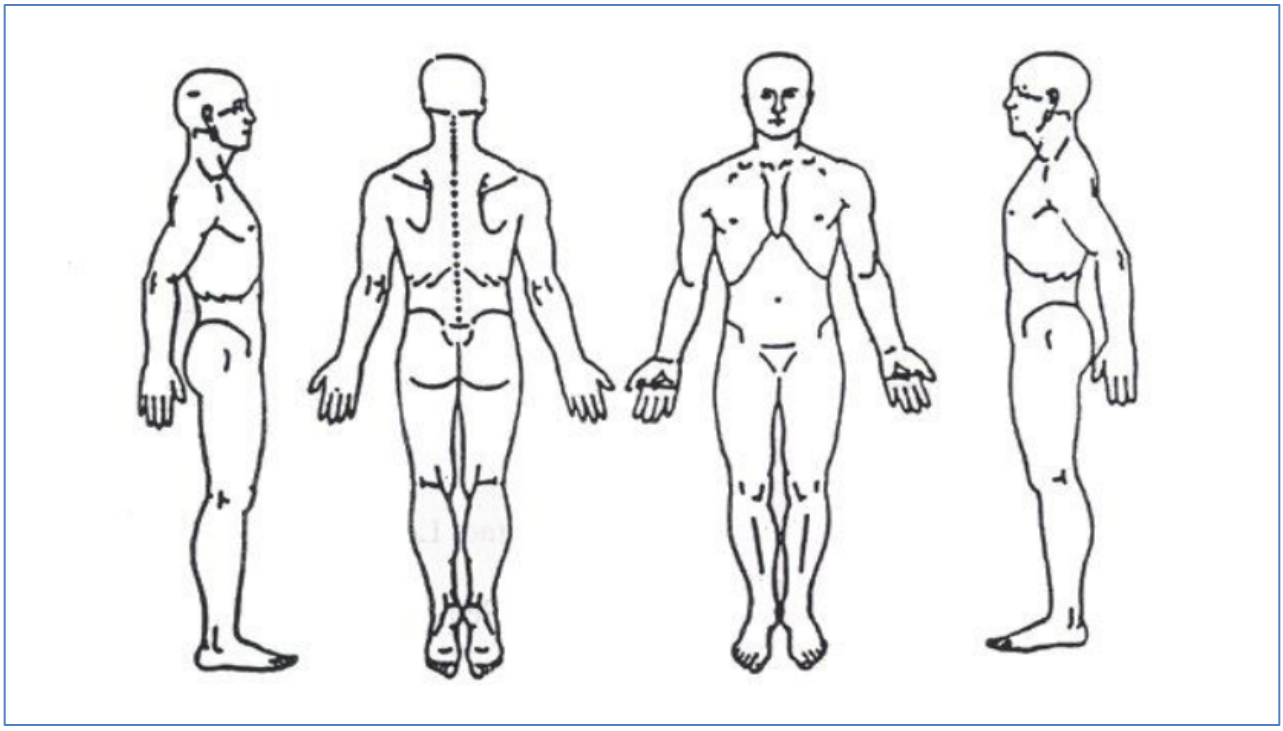
Client Signature: _____ Date:_____

Parent or Guardian Signature (if a minor): _____ Date:_____

Anchored Massage Therapy

Patient Intake Form

Please indicate any areas where you presently suffer pain or discomfort by **circling** that area on the diagram:



Next to each circle please rate your pain on a scale of 1-10.

Mankoski Pain Scale

0	Pain Free	No medication needed
1	Very minor annoyance-occasional minor twinges	No medication needed
2	Minor annoyance-occasional strong twinges	No medication needed
3	Annoying enough to be distracting	Mild painkillers are effective (Aspirin, Ibuprofen, etc.)
4	Can be ignored if you are really involved in your work, but still distracting	Mild painkillers relieve pain for 3 to 4 hours
5	Can't be ignored for more than 30 minutes	Mild painkillers reduce pain for 3 to 4 hours
6	Can't be ignored for any length of time, but you can still go to work and participate in social activities	Stronger painkillers (Codeine, Vicodin) reduce pain for 3 to 4 hours
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (Oxycontin, Morphine).
8	Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3 to 4 hours.
9	Unable to speak. Crying out or moaning uncontrollably--near delirium.	Strongest painkillers are only partially effective.
10	Unconscious. Pain makes you pass out.	Strongest painkillers are only partially effective.

Signature _____ Date _____

Anchored Massage Therapy

Patient Intake Form

Last Minute Cancellation and No Show Fees

Please note that your time commitment to Rachel Hays, LMP begins the moment you schedule your appointment. If you need to cancel or reschedule please give at least **24 hours** if you are not going to be able to make your scheduled appointment. If less than 24 hours is given you will be charged **$30.00** and will be expected to pay that amount before your next appointment.

Payment

As a Patient of this office, you are responsible for payment at the time of service or when supplies have been given. If your provider is contracted with your insurance all deductibles, copays/coinsurances, and/or any outstanding balances are the **patient's responsibility** and are due at the time of service. Anchored Massage Therapy accepts cash, personal checks, credit and debit cards.

Insurance

Anchored Massage Therapy will gladly bill your insurance after your service is provided, so long as it is an insurance carrier your provider is contracted with and we have a **prescription** in hand at time of service. Anchored Massage Therapy will follow the instructions given by the insurance carrier, however ultimately it is your responsibility to know what your benefits are and be aware of the charges associated along with it including any discrepancies that may occur. It is your responsibility to keep track of your deductible, copay/coinsurance, maximum benefits, and other liabilities included with your insurance plan's coverage.

HIPAA

I authorize Rachel Hays, LMP to release my medical records as requested by my insurance company, attorney, or other health providers involved in my care. I understand these records will be used for pertinent patient care, administrative and legal purposes, including verification, evaluation, consultation and negotiation of my health claim.

HSA or Benefit Cards

If you would like to pay for a wellness visit with your HSA or Benefit Card you need to be aware of a few things. Most companies want a receipt to prove the treatment was a medical necessity. To prove your rendered service was a medical necessity there needs to be a prescription on file from a Doctor. This can differ from company to company, but know that if your company rejects the payment you will be responsible for the balance.

Authorization for Treatment and Acknowledgement of Policies

I, the undersigned, hereby acknowledge that the care being provided by Anchored Massage Therapy is intended to improve my health and/or condition. I authorize the release of any medical or other information necessary to process my claims. I authorize Rachel Hays, LMP to perform treatment necessary for my care, including but not limiting to different styles of Massage Therapy, Manual Therapy, Stretching, Gua Sha Therapy, Cupping Therapy and Hydrotherapy procedures. I understand that every effort will be made to fully disclose information about the procedures used. If I have a question about these procedures I will ask until my question is properly answered. I acknowledge that there is no guarantee or warranty express or implied, concerning the outcome of any of the procedures used in the course of my care. I understand and agree to the above Policies and Insurance Requirements. I will abide by the terms and conditions set forth above.

_____ _____

Signature Date

_____

Name Printed