Performance Bodywork Client Registration

Legal Name: ________________________________ **Date of Birth**: ____ /____ /______ **Sex**: Male □ Female □

Address: __________________________________ **City**: _________________ **State**: ____ **Zip Code**: ________

Home Phone: (____) _____________ **Cell Phone**: (____) ______________

Email Address: _______________________________________ Please list to receive appointment reminders

Emergency Contact: ______________________________ **Phone Number**: (____) ______________
Relationship to Emergency Contact: ___________________________

Marital Status (for insurance purposes): □ Single □ Married

How did you hear about us? Who referred you? _____________________________________

Employment Status: □ Full Time □ Part Time □ Student □ Retired □ Unemployed

Employer Name: __________________________________ **Job Title**: _______________________

Work Phone: (____) ______________ ext: _____

Insurance Information (if applicable)

Provider: ___________________________ **ID Number** (include any letters): ________________________

Provider Phone Number: (____) _______________

Subscriber Name (if different from patient): ________________________________

Subscriber Date of Birth: ____ /____ /_______

Relationship to Subscriber: □ Spouse □ Child □ Other _____________

What treatments are you receiving and/or interested in?

□ Massage Therapy □ Fascial Stretch Therapy □ NovoTHOR □ Normatec

Complete Health Intake on Next Page

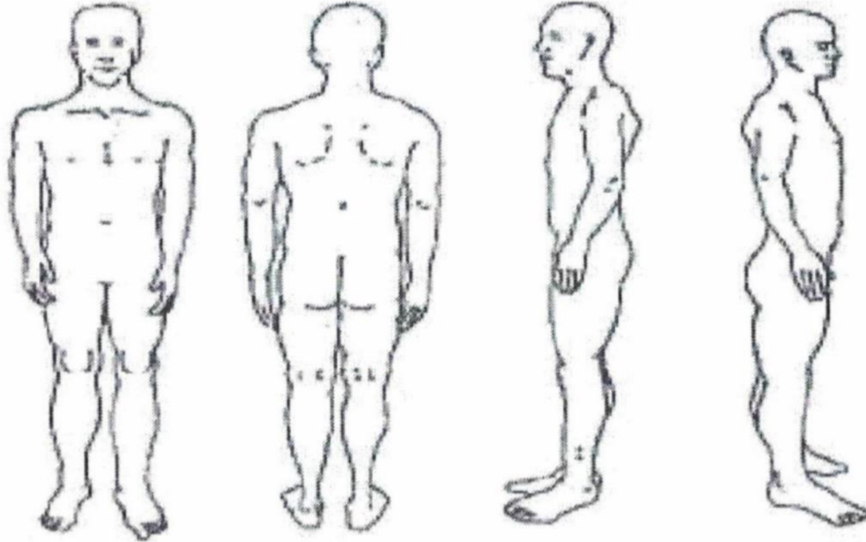
Health Intake

Have you ever had a massage/FST before? □Yes □No **When was the last time (approx.)?** ______________________

Were you in a Motor Vehicle Accident? □Yes □No **If so, what State did it occur?** □OR □WA □Other____
Date of auto injury? ____________________

Current Complaint/Goals for visit? ____
Mark any symptoms you are having:
□Pain □Dull Ache □Burning □Tingling/Numb □Stiffness □Sharp/Shooting □Pain w/Movement □Inflammation

When did the symptoms start (onset of injury/complaint)? ____



Rate the intensity of your symptoms: (circle) 0 1 2 3 4 5 6 7 8 9 10
How often do you experience these symptoms? □Constant □Frequent/Often □Intermittent/Sometimes

Have you received any treatment yet for your current condition? □Yes □No
If so, by whom? ______________________________

Are you currently taking any medications or substances? (list prescription or over-the-counter) ___________________
____

Are you currently pregnant? □Yes □No □NA
Describe your daily activities (work, exercise, computer use, etc) ____
Any allergies to oils, lotions, or ointments? ____
Please list any surgeries, past injuries you've had, including approx. dates: ___________________________________
____

Health History

(check any area you have any concerns, or conditions)

□Musculoskeletal □Circulatory □Respiratory □Neurological □Reproductive □Skin □Digestive
□Eyes □Urinary □Psychological □Immune System □Cardiovascular □Diabetes □Allergies
□Cancer/Tumors □Drug/Alcohol Use □Other ______________________________________

Please explain any of the conditions marked above, or that were not listed: _____________________________
____
____

<u>Massage Therapy, Fascial Stretch Therapy, Normatec and NovoTHOR Session Consent</u>

Massage Therapy is not a substitute for a medical examination or diagnosis. It is recommended that I see a physician for any physical ailment that I have. I understand that the massage therapist does not prescribe medical treatments of pharmaceuticals, and does not perform any spinal adjustments. I am aware if I have any serious medical diagnosis or have recently had surgery, I must provide a physician's written consent prior to services.

The massage therapist will not perform breast massage on female clients without the written consent of the client prior to the massage session.

I understand that NovoTHOR Whole Body Photobiomodulation Pod is a laser and light therapy modality, intended to stimulate healing and relieve pain.

The NovoTHOR session should not be painful and you should feel no significant heat, but you may feel a pleasant warmth.

If uncomfortable for any reason the client or therapist may ask to end the massage or NovoTHOR session, and the session will be ended immediately.

I am aware that massage therapy sessions are done in compliance with the Oregon Board of Massage Therapy. Draping will be necessary. Athletic attire is recommended for Fascial Stretch Therapy sessions in order to obtain full range of motion during the session. Massage and Fascial Stretch Therapy is for therapeutic purposes only. Any inappropriate, or sexual behavior will result in the session being ended immediately, and without refund.

If you are the <u>parent or legal guardian of a child under 18</u> receiving Massage Therapy, Fascial Stretch Therapy, Normatec or NovoTHOR sessions and waive the option to be present during the session, please initial here. _______

By signing below I fully understand and give my consent for treatment.

___________________________	___________________________	____ / ____ / _____
Participant's Printed Name	Signature	Date
___________________________	___________________________	____ / ____ / _____
Participant's Parent/Guardian	Signature	Date

Financial Agreement

I understand that I am responsible for all charges for all services provided. In the event my insurance denies payment, or makes partial payment, I am responsible for any balance due. I authorize my insurance benefits to be paid directly to Performance Bodywork LLC, and authorize the release of any medical information necessary to process the claims. Advertised "self pay rates" are "relaxation/maintenance" massages offered to clients who do not have an active medically necessary reason for treatment. There is no insurance to bill and no referral from a physician that establishes medical necessity. They are offered to all patients for maintenance care when paid at the time of service and are not billable to insurance. Rates for medically necessary treatment are as follows: Therapeutic Massage - 97124 billed at $45.00/unit. Manual Therapy - 97140 billed at $50.00 a unit. I agree to pay full price for any scheduled appointment if I fail to show up for my appointment or cancel/reschedule without giving at least 24 hour notice.

Late Arrival, Cancellation and No Show Policies

Late Arrival:
All clients are asked to arrive at least 5-10 minutes before your scheduled appointment time. Therapist cannot go over the allotted time. Late arrivals may still be seen by therapist, but their treatment time will not go over the original scheduled time.

Cancellation Policy:
All cancellations require 24 hour notice. Any cancellation made less than 24 hours from the session time will be charged the full session rate. An exception will be made if there is a contagious illness, sudden emergency, or inclement weather.

No Show Policy
If a client "NO SHOWS" an appointment the full sessions rate will be charged. An exception will be made if there is a contagious illness, sudden emergency, or inclement weather.

By signing below I fully understand and agree to the Financial Agreement.

____________________________	____________________________	____ / ____ / _____
Participant's Printed Name	Signature	Date
____________________________	____________________________	____ / ____ / _____
Participant's Parent/Guardian	Signature	Date

Notice of Privacy Practices

In accordance with the Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information, and provide you with a description of their privacy practices. This notice identifies your rights regarding the facilities use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can get access to this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for your future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by Performance Bodywork LLC.

Your health information will be used and disclosed to provide treatment and services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us, and we will disclose health information about you to that doctor. We will use and disclose health information about the treatment and services you receive from us to insurance companies so we can bill and receive payment. Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for medical massage.

Although your health record is physical property of Performance Bodywork LLC, you have the right to inspect and, upon written request, obtain a copy of your health information.

If you believe that your health information we have about you is incorrect, or incomplete, you may request in writing that we amend your health information for as long as this office keeps the information.

Our disclosure of your health information is limited to: this office, the physician who prescribed physical medicine, your insurance company, your attorney, and you. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient, and the patient's health information will be disclosed to the parents or guardian.

If you believe your privacy rights have been violated, you may file a written complaint to the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Room 509f, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.

By signing this form your hereby acknowledge that Performance Bodywork may release your Protected Health Information to carry out payment and treatment operations.

I have read and understand the Notice of Privacy Practices of Performance Bodywork.

___________________________	___________________________	____ / ____ / _____
Participant's Printed Name	Signature	Date
___________________________	___________________________	____ / ____ / _____
Participant's Parent/Guardian	Signature	Date