PERFORMANCEBODYWORK
THERAPEUTIC & SPORTS MASSAGE

Client Registration

Name: _____ **Date of Birth**: _____ **Gender**: Male ☐ Female ☐

Address: _____ **City**: _____ **State**: ____ **Zip Code**: _____

Home Phone: (____) _____ **Cell Phone**: (____) _____

Email Address: _____ Please list to receive appointment reminders

Emergency Contact: _____ **Phone Number**: (____) _____

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: _____

Massage Intake

Have you ever had a massage 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? _____

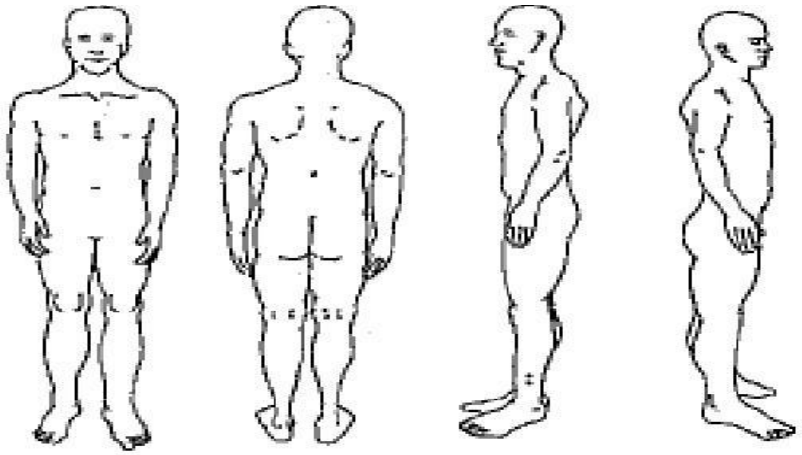
Current Complaint/Goals for visit? _____

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)? _____

Locate on body diagram where you are experiencing these symptoms



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/Always ☐Intermittent/Sometimes

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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: _____

_____

Consent to Treatment: I am aware of the benefits and risks of massage, and give my consent for massage treatment. I understand that there is no implied, or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I understand that a massage therapist is not legally able to diagnose a condition. I have stated all medical conditions on the massage intake that I am aware of and will inform my practitioner of any changes in my health status. I will participate fully as part of my health care team. I understand that I, or my therapist may end any session, at any time for reasons including, but not limited to: sexually suggestive behavior, violent behavior putting either client or therapist in danger, pain or discomfort, client or therapist is under the influence of drugs or alcohol, or personal preference to end the massage.

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, and authorize the release of any medical information necessary to process the claims. Advertised "maintenance care 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.

By signing below I fully understand and agree to the Financial Agreement, and give my consent for treatment.

Client Signature: _____ **Date**: _____

-or-

Parent/Guardian Signature (for minors): _____ **Date**: _____

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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 this 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.

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, 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.

Client Signature (or parent/guardian of client): _____

Date: _____