Female Massage Therapy Intake

Massage Mundo INS2012

CONFIDENTIAL CLIENT INFORMATION FORM

Name _____
Address _____
City, State, ZIP _____
Telephone (best # to call) _____
Telephone (mobile) _____
Date of Birth _____
Email: _____

Marital Status: Single Married Partner
Occupation _____
Employer _____
Referred By _____
Earn free massages every 3 clients you send to us!
Emergency Contact _____
Emergency Telephone _____

Insurance Information

Subscriber Full Name _____
Date of Birth _____
Related to Patient: Self Spouse Child
Employer: _____

Insurance Company _____
Customer Service # _____
ID # _____
Group # _____

Health History

Please circle which describes your stress level: Low 1 2 3 4 5 6 7 8 9 10 High
Please circle which describes your pain level: Low 1 2 3 4 5 6 7 8 9 10 High

Please answer the following questions:

Yes No

- ☐ ☐ Have you ever had a professional massage before?
- ☐ ☐ Do you wear contact lenses?
- ☐ ☐ Do you have any skin problems or allergies? Please list: _____
- ☐ ☐ Are you pregnant? If so, at what stage? _____
- ☐ ☐ Do you exercise regularly or participate in any sports?
  If yes, what kind and how often? _____
- ☐ ☐ Do you take Rx medication? If yes, please list: _____
- ☐ ☐ Have you suffered an acute injury recently?
  If yes, please describe: _____
- ☐ ☐ Have you ever had surgery?
  If yes, please describe: _____
- ☐ ☐ Do you have varicose veins or blood clots?
- ☐ ☐ Do you have arthritis?
- ☐ ☐ Do you have heart problems?
- ☐ ☐ Do you have spinal problems?
  If yes, please describe: _____
- ☐ ☐ Do you have high blood pressure?
- ☐ ☐ Do you have any infectious or contagious disease?
- ☐ ☐ Do you have any areas that need special attention?
  If yes, please describe: _____
- ☐ ☐ Do you have any other medical condition that your practitioner should be aware of before you receive massage?
  If yes, please specify: _____

I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health.

Purpose of Massage I understand that massage is given here for the purpose of stress reduction, relief from muscular tension, spasm, or pain or for increasing circulation or energy flow.

I understand that the massage practitioner does not diagnose illness, disease or any other physical or mental disorder. As such the massage practitioner does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulation. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Cancellations If I am unable to keep an appointment, I will provide at least a 24 hour notice of cancellation. I understand that in the event sufficient notice is not given, I will be charged for the missed appointment.

Signature _____ Date_____

Covered Intake with Client LMP Signature: _____

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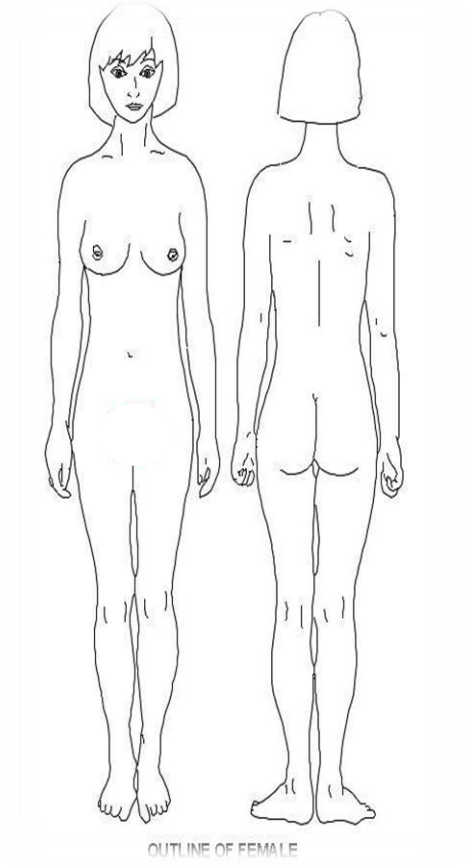
Draw Today's Symptoms on the Figures Identify CURRENT symptomatic areas you are feeling today. Circle the area around each letter, representing the size and shape of each symptom location.

(*Key:* ***P*** *= Pain or tenderness;* ***S*** *= Joint or muscle stiffness;* ***N*** *= Numbness or tingling)*

Comments: _____

NOTICE OF PRIVACY PRACTICES


OUTLINE OF FEMALE

This notice describes how your health information may be used and disclosed and how you can get access to this information.

Please review it carefully.

New federal laws require that we provide each of our patients with an official notice of our privacy practices. This notice will inform you of ways we use and share your information and it will describe your rights and our duties regarding the use and disclosure of health information.

Law requires us to:

-Keep your health information private
-Give you this Notice of Privacy Practices
-Abide by the terms of the Notice of Privacy Practices currently in effect

We have a right to:

-Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.

If we make changes, we will update this notice and make the new notice available upon request.

Listed here are some of the ways we may use or disclose your information without your specific consent or authorization. Not all possible uses or disclosures are listed.

-For Treatment: We may use health information about you to provide you with treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or to other people who are taking care of you. We may also share health information you with your other health care providers to assist them in treating you.

-For Payment: We may use and disclose your health information for payment purposes.

-For Health Care Operations: We may use and disclose your health information for our health care operations. For example, we may use healthy information about you to review our treatment and services and evaluate the performance of our staff in caring for you.

-Other Possible Uses and Disclosures:

- In response to legal proceeding
- For other healthcare provider's treatment activities
- For other covered entities and provider's payment activities
- In case of threat to public health or safety
- To notify a family member in certain emergency situations
- To workers' compensation or similar programs for processing of claims
- In domestic violence or neglect situations
- Other uses and disclosures not in this notice will be made only as allowed or required by law or with your written authorization.

The health and billing records we create are the property of this facility. The health information in it, however, generally belongs to you.

You have a right to:

-Request and receive from us a copy of the most current Notice of Privacy Practices
-Look at or receive copies of your health information. You may make this request in writing and we have a form available for that purpose. We reserve the right to charge a fee for the costs for copying, mailing or other supplies associated with your request.
-Ask us to restrict certain uses and disclosures. You must submit this request in writing. We are not required to grant the request but will comply with any request granted if possible.
-Have us review a denial of access to your health information, except in certain circumstances
-Ask us to change your health care information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical record, and included with any release of your records.
-Request a list of disclosures of your health information. The list will not include disclosures to third party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
-Ask that your health information be given to you by other means or at another location. Please sign, date and give us your request in writing. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.
-Cancel a prior authorization to use or disclose health information by giving us a written revocation. Your revocation does not affect any information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance.

If you have questions or wish to report a problem, you may contact Yvonne Garcia at 206-718-1455. If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also file a complaint with Yvonne Garcia at Massage Mundo, or with the U.S. Secretary of Health and Human Services. All complaints must be in writing. You will not be penalized or discriminated against for filing a complaint.

Signature _____ Date _____

MEDICAL MASSAGE POLICIES & RATES

To receive Medical Massage, you must present a written prescription for therapeutic massage that includes appropriate diagnosis code(s). In addition, we also prefer to receive a treatment plan provided by your licensed doctor, chiropractor, naturopath, etc.

Medical Massage treatment is provided only for the prescribed area(s) and condition(s) diagnosed by your licensed medical professional (doctor, chiropractor, naturopath, etc.). If you request massage unrelated to your prescription (not covered by your insurance), you will be responsible for full payment of those massage charges.

Medical Massage:

- Requires the application of advanced knowledge and skills.
- Requires continued communication with you, the referring doctor(s), insurance company(ies), and maybe your attorney(s).
- Requires more time to prepare/provide treatment documentation/reports for the doctor, insurance company, attorney etc.
- Frequently incurs lengthy payment delays resulting from the insurance billing and legal settlement processes.

These additional requirements necessitate a fee schedule for Medical Massage (medical care) which differs from Relaxation Massage.

Fee Schedule for Medical Massage 97112, 97124, 97140 Massage Therapy, $150 per hour ($37.50 per 15 minutes - 1 unit)
97110 Ice and Heat Therapy ($15 per 15 minutes - 1 unit)

If Massage Mundo's treating Therapist is a contracted provider for your medical health plan, then the Medical Massage fees for service are set by that contract. Those fees may vary from health plan to health plan. It is your responsibility to check with your insurance plan to determine the amount of coverage your plan provides. Be prepared to provide any co-payment and/or coinsurance amount(s) that your insurance plan requires at the time you receive service.

Payment Policies Massage Mundo (or our billing service) will ONLY bill your insurance company directly under the following conditions:

- **Medical Health Care Plan Coverage**: Verbal verification of coverage
- **Workers Compensation Claims**: Verbal verification of coverage
- **Auto Accident Claims***
- **PIP**: Verbal verification of coverage
- **Second Party Coverage***:* Written verification of coverage
- **Third Party Coverage***:* Signed 3rd Party Coverage policy and letter of guarantee signed by the patient's attorney.

* A 30% cash / check discount is available if payment for Medical Massage is made in full at the time services are provided. All insurance account balances are due 90 days from the date of service, and any outstanding balances incur a 1% per month compound interest charge. **Past due accounts over 90 days may be subject to a $15 re-billing fee**. We will initiate collection procedures if no payment is made on your account for 120 days. You will be responsible for payment of reasonable attorney fees, collection agency fees, and any court costs incurred to collect your account.

Office Policies Appointments cancelled less than 24 hours prior to the scheduled appointment time will be subject to a charge equal to 50% of the massage service booked. Appointments not kept will be charged 100% of the massage service booked. Even if the appointment was a Medical Massage appointment, you will be responsible for payment out-of-pocket (your insurance company will not pay for your missed appointment).

NO SHOW – CANCELLATION POLICY

We appreciate all of our Massage patients and we do understand that there will be times where unforeseen incidences happen to interfere unexpectedly with your appointment schedule. However, due to the high volume of "no shows" and last minute cancellations, we have to enforce our No Show – Cancellation policy.

We request a 24-48 hour cancellation notice. However if you do not provide a minimum 24-hour notice, we reserve the right to charge you for the Massage Therapist's time. In addition we will have your credit or bank card on reserve and will draft your card at the time of your appointment with the following fee schedule:

First time: $40 Second time: $50 Third and thereafter: $60

Please be aware that this charge is NOT covered by your insurance and therefore you will be personally accountable and responsible. Thank you for your understanding and cooperation. We truly appreciate you choosing Massage Mundo for your massage therapy needs.

This form is automatic required form for all current and past patients. This is required and MUST be signed prior to receiving massage therapy by Massage Mundo. (In case you schedule over the phone and are a new patient, this form will be mailed or faxed to you, and must be promptly be faxed back to our office. This MUST be returned to verify your penciled-in appointment; until then your appointment will not be confirmed.) A copy will be provided at the time of staff authorization. If you have any concerns, please inform us by speaking to the current administrator.

_____	_____	_____
Patient **Print Name**	Patient **Signature**	Date
_____	_____	_____
Thearpist **Print Name**	Therapist **Signature**	Date