

New Patient Massage Intake Form



Patient Information:

Legal Name _____ Today's date ____ / ____ / ____
Preferred Name _____ Date of Birth ____ / ____ / ____ Age ____
Address _____ City _____ State ____ Zip ____
Email _____ Best contact Phone # (____) ____ - ____
Emergency Contact _____ Relationship _____ Phone (____) ____ - ____
Primary Care Provider (MD/ND) _____ Phone (____) ____ - ____
How did you hear about us? _____

Insurance & Payment for Care:

Commercial health insurance Self MVA/Car insurance Workers Compensation

Insured Name (On Card): _____ Insured Date of Birth: _____
Insurance Name: _____ Phone: _____
Send Claims to Address: _____
ID/Policy #: _____ Group #: _____
Secondary Insurance?: Yes No (If yes, we will ask for your secondary insurance info.)

Health Information:

What is the primary reason for your visit today? _____
How long has this been a problem? _____
What other treatments have you tried to address this concern? _____
Please list any other health concerns you would like to address during your visit:
1. _____ 2. _____ 3. _____
What are your treatment goals and expectations? _____

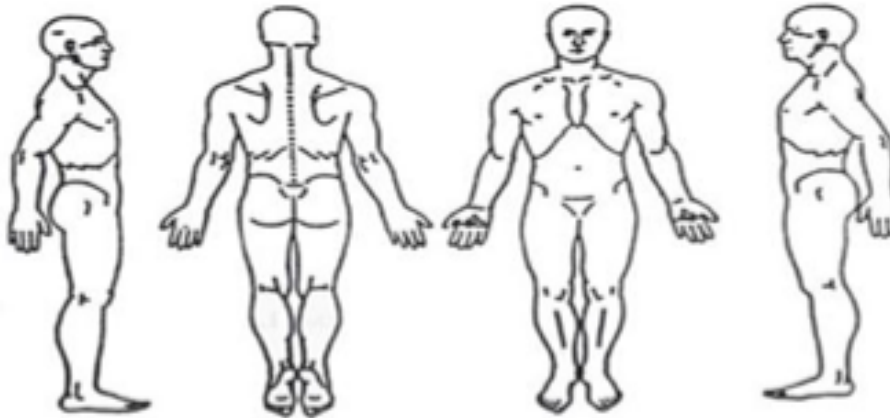
Please list (with approx. dates) any serious illnesses, injuries, or hospitalizations: _____

Please list any medications, supplements you are currently taking: _____

Please list any allergies (drugs, chemicals, food): _____

SHOW ALL AREA(S) OF PAIN OR DISCOMFORT Mark the areas on the figures below, using the appropriate symbols, where you feel the described sensations. Mark areas of radiating pain. Include all affected areas.

Numbness Pins & Needles Stiffness Burning Aching Stabbing
 ... 000 sss xxx >>> ///



On a scale of zero to ten, I rate my discomfort as follows: _____
 (0=no discomfort 10=severe-unable to perform daily tasks) 0 5 10

Family Medical History (please specify family member):

- Cancer _____ Kidney Disease _____
- _____ Heart Disease _____ Stroke _____
- _____ High BP _____
- Diabetes _____
- Alzheimer's _____ Arthritis _____
- Osteoporosis _____ Anxiety _____
- _____ Depression _____
- Mental Illness _____

Review of Systems (Please check all that apply):

General:

- chills fatigue night sweats weight loss trouble sleeping fever weight gain none of these

Eyes/Vision:

- blindness change in vision redness photophobia(sensitivity to light) blurred vision double vision none of these
- glaucoma flashing lights cataracts wear glasses/contacts itching eye pain

Ears, Nose and Throat:

- bleeding ear drainage hearing loss nosebleeds sore throat dentures none of these
- fainting rhinorrhea history of head difficulty tinnitus snoring
- ear pain hoarseness injury swallowing (ringing in ears)
- discharge sore tongue sinus infections postnasal drip TMJ problems nasal congestion
- loss of sense of smell dizziness headaches neck pain

Respiration:

- asthma coughing up blood sputum production cough shortness of breath wheezing none of these

Cardiovascular:

- angina (chest pain or discomfort) shortness of breath with exertion or exercise waking at night w/ shortness of breath leg pain/ache none of these
- tightness low blood pressure swelling of legs heart problems
- varicose veins heart murmur difficulty breathing lying down ulcers
- high blood pressure palpitations

Gastrointestinal:

- abdominal pain diarrhea indigestion jaundice heartburn nausea none of these
- hemorrhoids difficulty swallowing change in appetite change in bowel habits constipation rectal bleeding

Female:

- birth control cramps irregular menstruation vaginal discharge pregnancy none of these
- breast lumps/pain hormone therapy breast feeding

Urinary:

- burning urination frequent urination blood in urine urgency incontinence none of these

Endocrine:

- cold intolerance excessive hunger sweating diabetes frequent urination unusual hair growth/ loss none of these
- excessive thirst heat intolerance voice changes excessive appetite change in appetite

Skin:

- changes in nail texture hair loss itching skin lesions / ulcers changes in skin color rash none of these
- numbness/tingling hives dryness open wounds/cuts history of skin disorders/conditions

Neurologic:

- dizziness limb weakness slurred speech numbness loss of consciousness unsteadiness of gait/ loss of balance none of these
- headache seizures loss of memory strokes sleep disturbance
- stress tremor facial weakness fainting

Musculoskeletal:

- stiffness redness of joints joint swelling trauma back pain muscle or joint pain none of these

Allergy:

- anaphalaxis itching nasal congestion rash food intolerance sneezing none of these

Neck:

- lumps pain stiffness swollen glands none of these

Psychiatric:

- stress nervousness depression memory loss none of these

Hematologic:

- anemia blood transfusion blood clotting bruising easily TB Hepatitis none of these
- HIV lymph node swelling open skin ulcerations/ abrasions bleeding easily communicable diseases

Hillclimb Chiropractic Clinic
Massage Therapy Consent for Care

1409 5th Ave | Seattle WA 98101 | 206-624-3590 | www.hillclimbclinic.com

I, _____ (print name) understand that massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, stretch connective tissues, and offer a positive experience of touch.

I understand that massage therapy is not a substitute for medical treatment, and that it is recommended that I concurrently work with my other healthcare providers for any condition I may have. I am aware that that massage therapist does not diagnose illness or disease, does not prescribe medications and that spinal manipulations are performed by Dr. Matt Brown-Ruegg.

I have informed the massage therapist of all my known physical conditions, medical conditions, allergies, prescription and over-the-counter medications and I will keep the massage therapist updated on any changes.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

Name (Please print)

Signature of patient or person legally authorized to give consent

date

Hillclimb Chiropractic Clinic

Massage Clinic Policies

If using insurance, please inquire as to rates. Wellness Massage or Wellness Acupuncture Rate is \$95 for one hour treatment.

Insurance and payment

- When we bill insurance for an out-of-network massage it is likely the insurance company will reimburse the patient rather than the provider of the service. If this occurs, we will need full payment in the amount the insurance reimbursed. Co-pays are due at time of service.
- Any deductible or co-pay must be paid at time of service.
- Any insurance checks sent to your home by the insurance company must be brought to our office within 3 days. With a copy of the payment stub indicating which services were paid.
- If your insurance company is not responding to our claims in a timely manner (60 days) you will be asked to call and/or write them to assist with collections for services rendered.
- **If your insurance company deems that services are not medically necessary, you will be responsible for any unpaid balance- as permitted by our contract with your insurance company.**
- There is a \$25 processing fee added to any account for any returned check.

First Time at the Clinic Policy

For all first time clients to the clinic payment for massage or acupuncture treatment is required beforehand. In addition, first time cash massage/acupuncture or out-of-state patients are required to provide a photo ID and completed intake form. If no photo ID is available, we reserve the right to refuse service.

Allergies & Cuts, Scratches or Other Breaks in Skin Policy

Please note massage lotions may contain trace amounts of almond/nut extracts, apricot and mango, avocado, coconut, etc. Upon request we have a nut-free gel for those with nut allergies. Please inform your therapist of any nut, fruit or vegetable allergies. For the safety of both client and practitioner, Hillclimb Chiropractic Clinic's policy is that massage practitioners wear Nitrile (non-latex) gloves if the practitioner has any cuts, scratches or other skin breaks on his or her hands or if the client has any cuts, scratches or other breaks in his or her skin in the areas covered in a massage treatment.

Early Arrival Policy

On occasion massage/acupuncture practitioners work out of the clinic alone. If you arrive early for an appointment and the door is locked, please wait at the door until your scheduled appointment time as your practitioner may be with another patient and unable to open the door. Also due to government regulations for all treatment facilities regarding patient privacy, we cannot allow patients to wait alone in the office to see the therapist while he or she is seeing another patient. We are very sorry for any inconvenience this may cause; we will do our best to keep you from having to wait.

Late Arrival Policy

Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time. If you arrive late, your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session.**

CANCELLATION & RESCHEDULING POLICY: 24-hour advance notice REQUIRED or you will be charged \$35.00 cancellation fee

- There is a \$35 fee for no show appointments.
- If cancelled within less than 24-hour notice and we are unable to rebook the appointment you will be charged the \$35 fee.
- Cancellation/Missed appointment fees cannot be billed to insurance carriers and is your financial responsibility.

I understand that the nature of massage therapy/bodywork is for the purpose of health improvement and relaxation. I have stated all known medical conditions and will inform and update my therapist of any changes to my medical health as necessary. I understand that my session will be immediately terminated due to any form of inappropriate behavior and I will be charged the full amount for that appointment. We are committed to professionalism and expect the same from our clients. We will not tolerate any inappropriate acts.

I have read and understand the above policy.

Signature

Date _____

Print Name



Hillclimb Chiropractic Clinic Consent for Use and Disclosure of Health Information (HIPAA)

Matt Brown-Ruegg, DC PS | 1409 5th Ave | Seattle WA 98101 | 206-624-3590 | www.hillclimbclinic.com

Matt Brown-Ruegg, DC PS DBA Hillclimb Chiropractic Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and/or healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our privacy policy is available upon request and on our website. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

Our Notice of Privacy Practices is available in full on our website at <http://www.hillclimbclinic.com/new-patients/>. Also, you can request a copy of our Notice of Privacy Practices, including any revisions by calling/emailing: (206)624-3590 or info@hillclimbclinic.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the email address above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke or decline this consent.

SIGNATURE

I, _____ (Print Name), have had full opportunity to read and consider the contents of this Consent for and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT- AVAILABLE UPON REQUEST



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Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Hillclimb Chiropractic Clinic to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I understand that standard text messaging rates may apply to any message. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

I understand I can opt out at any time by calling 206-624-3590 and asking to be removed from appointment reminders and other communication.

Patient Name: _____ Date: _____

Signature: _____

Example of a Text Reminder from Hillclimb:

Hello Tim, This is a reminder for your CHIROPRACTIC appointment tomorrow at 1:00PM. Please call 206-624-3590 with questions. Text STOP to opt-out.