Confidential Health Form

Please Print Clearly

Name _____ Date of Injury/Accident: _____

Address _____ Date of Birth _____

City _____ ST _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Occupation _____

Employer _____

Emergency Contact / Relationship _____ Phone _____

Consent for E-Mail and Text Notification

_____ _____

E-Mail Address (PRINT CLEARLY) Text Number (PRINT CLEARLY)

Referring Provider

Name: _____ Permission to Contact HealthCare Team Members?

Address: _____ No Yes (please initial if yes)

City: _____ State: _____ Zip: _____ Phone: _____

Primary Health Insurance Information

Insurance Co: _____ ID #: _____ Group #: _____

Member Name: _____ Self / Spouse / Child Date of Birth: _____

List Past Surgeries/Injuries/Major Illness and Dates: _____

List **All** Medications you are currently taking, including Aspirin, Sinus, Heartburn, Vitamins, Supplements, etc:

List all Allergies: _____

Why You are Here

Injury/Accident _____ Chronic Condition (specify) _____ Other _____

How did you hear about Me/Kia Ora Bodyworks? _____

What are your goals for receiving massage therapy treatment? _____

Are there any other conditions/health issues I should be made aware? _____

COVERAGE BY ANY INSURANCE PROVIDER (HEALTH, PIP, LNI) WILL REQUIRE A PHYSICIAN'S PRESCRIPTION/ORDER WITH DIAGNOSIS CODES. IF YOU DO NOT HAVE A PRESCRIPTION/ORDER, FULL PAYMENT IS REQUIRED AT TIME OF SERVICE.

Kia Ora Bodyworks
kiaorabodyworks@gmail.com
509-542-9256

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Please read and sign to confirm that you understand and accept the following conditions. As a courtesy to my clients, I will bill your primary Health Insurance, if that information is made available before your first visit.

Please be aware that your medical insurance is a contract between you and the insurance company, and I am not a party to that contract. As such, it is your responsibility to verify what Massage Therapy treatment benefits you are entitled to receive and what restrictions apply. Your estimated portion (co-pay/co-insurance) is due at the time of each service.

All N.S.F. (returned) checks will be charged a $50.00 fee.

I hereby authorize the release of medical information necessary to process my insurance claim to my attorneys, healthcare providers and insurance managers. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information. Initial _____

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Cancellation/Missed Appointment/No Show Policy:

I agree to provide twenty-four (24) hour cancellation notice. If I fail to do so, I agree to pay $80.00. **(Please note that insurance companies do not pay this, you do)**. Initial _____

Patient Responsibilty:

I agree, I am ultimately responsible for **all** services rendered whether or not my insurance company deems those services necessary, usual or customary, or **denies payment for any reason.** If further action is required to gain funds, I agree to pay **all** additional expenses necessary, including, but not limited to Lien fees, collections fees, filing fees, release fees and copy fees, etc. In the event of default, venue will take place in Franklin County. Initial _____

I agree, if a Client StatementiInvoice is issued showing balance due, balance will be paid in full 30 days from statement date. Subsequent monthly Client Statements will be assessed a monthly re-billing fee of $7.00, commencing with second billing cycle. Initial _____

Acknowledgement and Consent for Massage

I understand the massage therapist (MT) will assess my tissues and is not able to diagnose and medical condictions. I understand it is my responsibility to report changes to my health.

Acknowledgement and Consent for Draping

Washington State law requires that draping is provided during a massage and ensures that the following areas will not be exposed during a massage: Breast/chest, genitals, and gluteal cleft. Any exception to this draping requires your special consent:

- Breast/chest drape may be removed for the duration of the session with prior verbal and signed consent.
- The drape may be temporarily removed from the gluteal cleft area and breasts specifically while these areas are being treated, with prior verbal and written consent. (Note: these treatment services are not offered at this location.)

If necessary for proper treatment, I consent for my torso to be temporarily uncovered during the massage. This consent is valid until I inform my therapist otherwise. Initial _____

If I feel uncomfortable, I understand that I may stop this treatment at any time during the session. I understand that I may have a witness in the room during treatment and that I will provide this person.

Signature: _____ Date: _____

Name: _____

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Rate Your Current Area(s) of Pain.

Circle the Number on the Scale; '0' (no pain) to '10' (worst pain possible).

Headache:	0	1	2	3	4	5	6	7	8	9	10
Face:	0	1	2	3	4	5	6	7	8	9	10
Neck:	0	1	2	3	4	5	6	7	8	9	10
Shoulder - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Arm - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Hand/Wrist - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Upper Back - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Mid Back - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Low Back - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Hip/Glutes - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Leg/Knee - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10
Foot/Ankle - Right / Left / Both:	0	1	2	3	4	5	6	7	8	9	10

Other (specify)

Current or Past Conditions

Current	Past		Current	Past		Current	Past	
____	____	headaches/migraines	____	____	chronic pain	____	____	varicose veins
____	____	vision problems	____	____	muscle or joint pain	____	____	blood clots
____	____	sinus problems	____	____	numbness/tingling	____	____	high/low blood pressure
____	____	jaw pain/teeth grinding	____	____	sprains/strains	____	____	diabetes
____	____	fatigue	____	____	scoliosis	____	____	cancer/tumors
____	____	depression	____	____	arthritis	____	____	skin infection/boils, etc…
____	____	sleep difficulties	____	____	tendonitis	____	____	Hepatitis (A,B,C, other)
____	____	heart condition	____	____	seizures	____	____	
____	____	HIV/AIDS	____	____	fever	____	____	other _____

Females: Pregnant? Y / N Gestation Schedule: _____ Weeks Due Date: _____

Provider Notes:

_____

_____

_____

Name _____

Date _____

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My Primary Complaint Is: (Circle one)

In My:

Head	Chest
Neck	Arms
Shoulders	Wrist
Back	Hands
Hips/Buttocks	Ankles
Thighs/Legs	Feet

The Pain is: Mild, Moderate, Severe

And: Constant, Frequent, Intermittent, Occasional

I Feel:

Burning/Tingling	Dizziness
Numbness	Headaches
Stiffness/Tightness	Other _____

The Pain Radiates to My:

Head	Chest
Neck	Arms
Shoulders	Wrist
Back	Hands
Hips/Buttocks	Ankles
Thighs/Legs	Feet

I have had these symptoms for:

1 2 3 4 5 6 7 8 9 10 11

Days Weeks Months Years

They are due to:

Auto Collision Date of Injury _____

State of Collision _____

Work Accident (LnI) Date of Injury _____

These symptoms get worse when…

Standing	Sitting	Twisting
Bending	Walking	Running
Lifting	Driving	Exercising
Cold	Heat	Daily Activity

The symptoms improve when…

Lying Down	OTC Medications	Rx Medications
Resting	Heat / Cold	Other Treatments

My Secondary Complaint Is: (Circle one)

In My:

Head	Chest
Neck	Arms
Shoulders	Wrist
Back	Hands
Hips/Buttocks	Ankles
Thighs/Legs	Feet

The Pain is: Mild, Moderate, Severe

And: Constant, Frequent, Intermittent, Occasional

I Feel:

Burning/Tingling	Dizziness
Numbness	Headaches
Stiffness/Tightness	Other _____

The Pain Radiates to My:

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The symptoms improve when…

Lying Down	OTC Medications	Rx Medications
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Name _____

Date _____

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