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: _____

Address: _____

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

Permission to Contact HealthCare Team Members?

No **Yes** **(please initial if yes)**

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

Confidential Health Form
Please Print Clearly

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: _____

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

Confidential Health Form
Please Print Clearly

Rate Your Current Area(s) of Pain.

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

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

Other (specify)

Current (C) or Past (P) Conditions

____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:

LnI/PIP: Working Not Working Full Time Part Time Modified

Name _____

Date _____

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

Confidential Health Form

Please Print Clearly

My **Primary** Complaint Is: **(Circle one)**

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

The Pain is:	Mild	**And:**	Constant
	Moderate		Frequent
	Severe		Intermittent
			Occasional

I Feel:	Burning/Tingling	Dizziness
	Numbness	Headaches
	Stiffness/Tightness	Other _____

The Pain Radiates to My:

Head	Back	Chest	Hands
Neck	Hips/Buttocks	Arms	Ankles
Shoulders	Thighs/Legs	Wrist	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 (PIP) Date of Injury _____

State of Collision _____

Work Accident (LnI/ WC) Date of Injury _____

These symptoms get worse when…

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

The symptoms improve when…

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

Name _____

Date _____

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