



## MESSAGE INTAKE FORM

Please fill out this form as completely as possible, the better you communicate, the better we can help you.

### Personal Information

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Text Reminders? Yes / No Phone Carrier: \_\_\_\_\_ (e.g. Verizon)

Emergency Contact \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

### Medical Information

Are you taking any medications?  Yes  No

If yes, please list name and use \_\_\_\_\_

Are you currently pregnant?  Yes  No

If yes, how far along? \_\_\_\_\_ Any high risk factors? \_\_\_\_\_

Do you suffer from chronic pain?  Yes  No

If yes, please explain \_\_\_\_\_

What makes it better? \_\_\_\_\_

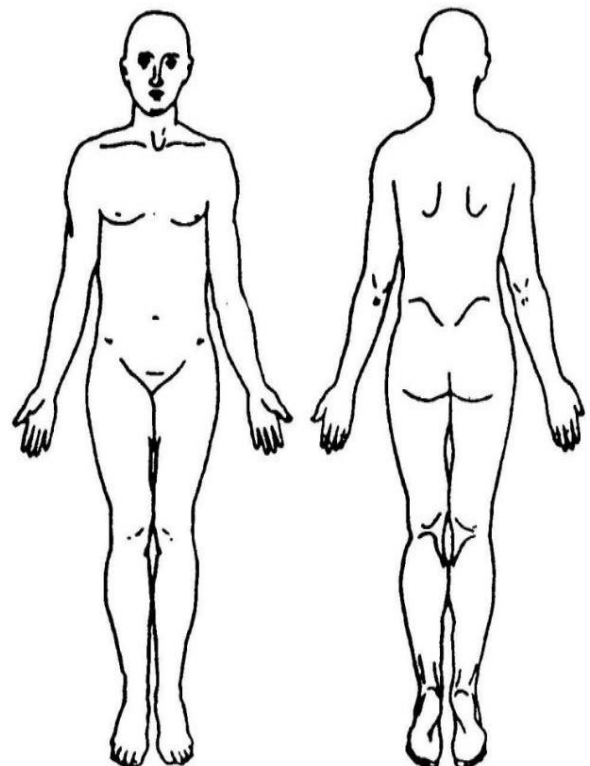
What makes it worse? \_\_\_\_\_

Have you had any orthopedic injuries?  Yes  No If yes, please list \_\_\_\_\_

Please indicate any of the following that apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches/Migraines |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> Joint Replacement(s)    | <input type="checkbox"/> Blood Clots         |
| <input type="checkbox"/> Numbness/Tingling       | <input type="checkbox"/> Neuropathy          |
| <input type="checkbox"/> Sprains or Strains      | <input type="checkbox"/> Fibromyalgia        |
| <input type="checkbox"/> Kidney Dysfunction      | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Heart Attack        |

PLEASE CIRCLE ANY AREAS OF DISCOMFORT



### Massage Information

Have you had a professional massage before?  Yes  No

What pressure do you prefer?  Light  Medium  Deep

Do you have any allergies or sensitivities?

If yes, please list \_\_\_\_\_

Are there any areas (feet, face, abdomen, ect.) you do not want massaged?  Yes  No

If yes, please list \_\_\_\_\_

## Informed Consent for Massage Therapy

I hereby request and consent to the performance of therapeutic massage therapy by the therapist(s) at Back to Health Chiropractic. Massage in general provides benefits of relief from muscular tension, spasm, and/or pain. I understand that massage therapists do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination and I will seek health care for those services. I accept that massage promises no long-term results nor will it cure my health problems.

The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.

By signing below, the patient agrees to the following:

- Privacy will be assured as I have the right to undress only to my comfort level and according to the requirements of the treatment.
- Draping will be used by the therapist as required to expose only those parts of my body that require treatment and/or as I choose to ensure my comfort during treatment.
- During treatment, you may experience some discomfort, but it should not be painful or unbearable. (Please communicate your comfort pain level with therapists.)
- If at any time during the treatment, I feel uncomfortable with the treatment for any reason, I have the right to request an immediate stop to the session or request modifications to the treatment, regardless of prior consent given.

## Massage Policy

Due to the limited availability in the massage therapy schedule book, we have certain guidelines regarding unexcused absences. If you are unable to make your appointment, please call at least 24 hours in advance. If you call 24 hours in advance, we can easily fill that appointment with another patient.

An unexcused absence is missing an appointment without calling 24 hours in advance. Of course, emergency absences are accepted. However, if it is not an emergency then you will be charged a **\$50.00 non-refundable fee**. If you miss 3 appointments that are classified as unexcused then you will need to pre-pay for your massage appointments at the time of scheduling and may be limited scheduling opportunities. If you arrive at your massage appointment 10 to 15 minutes late without calling to notify the massage therapist; the massage therapist is not obligated to stay and may leave by the time you make it to the appointment.

I have read the above statements and agree to them:

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**YOUR FINANCIAL POLICY AGREEMENT WITH:  
BACK TO HEALTH CHIROPRACTIC CLINIC**

**HEALTH INSURANCE:** (In order for us to bill insurance for massage therapy, a medical diagnosis and referral by a medical doctor or chiropractor is **REQUIRED**) Once insurance coverage is verified, as a courtesy, we will be glad to bill your insurance company. You will be required to pay the amount not covered by your insurance company at each office visit.

- **BENEFIT QUOTES:** Benefit quotes from your insurance company are not a guarantee of payment, nor approval of treatment. They are solely to obtain general benefit & eligibility information as a guideline for payment.
- **INSURANCE DEDUCTIBLE:** If you have a deductible, it is your responsibility to pay for any portion that your insurance company does not cover until you have met your deductible requirements.
- **MASSAGE THERAPY:** All deductibles, co-pays and co-insurance apply and are expected at the time of treatment. Please note our massage therapists are in a very limited number of insurance networks and your insurance may not cover the massage.

**MEDICARE:** Please be advised that Medicare B will only pay for manipulations of the spine and there is a 20% co-insurance that is subject to the annual deductible first. **\*\*MEDICARE WILL NOT PAY FOR EXAMS, X-RAYS, OR MASSAGE\*\***

**PRIVATE PAY:** If you do not have health insurance, you will be responsible for all health care expenses incurred during treatment. It is your responsibility to keep your account current and make payment arrangements that are suitable for all parties.

**PERSONAL INJURY PROTECTION AND AUTO ACCIDENTS:** Cases will be billed directly to the insurance company, providing the appropriate paperwork has been filled out correctly and the claim has been filed.

- If someone else is responsible for the auto accident, you must still notify your auto insurance so that they are aware of an accident & can provide you with a claim number for your medical bills to be paid. This is a standard procedure with auto insurance companies; your insurance company will pay your medical bills upfront (if you have personal injury coverage) and will be reimbursed from the at-fault party's insurance company when your claim is settled.
- Even if the at-fault party's insurance agrees to pay for your medical bills, they have no obligation to pay them, and may exercise this right, leaving you fully responsible for your medical bills.

**WORKERS COMPENSATION:** Workers' compensation claims will be billed directly to the insurance company provided the paperwork has been filled out correctly and claim has been filed. Massage benefits are limited by Department of L&I. **\*\*IF YOU ARE DENIED WORKERS COMPENSATION, YOU WILL BE HELD RESPONSIBLE FOR ALL BILLS INCURRED. \*\***

**ALL PAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED**

I have read, agree, and understand the above financial policy:

SIGNATURE: X \_\_\_\_\_

DATE: \_\_\_\_\_