FALLING WATERS

INJURY & HEALTH MANAGEMENT CENTER

APPOINTMENT CHECKLIST

MASSAGE THERAPY PATIENTS:

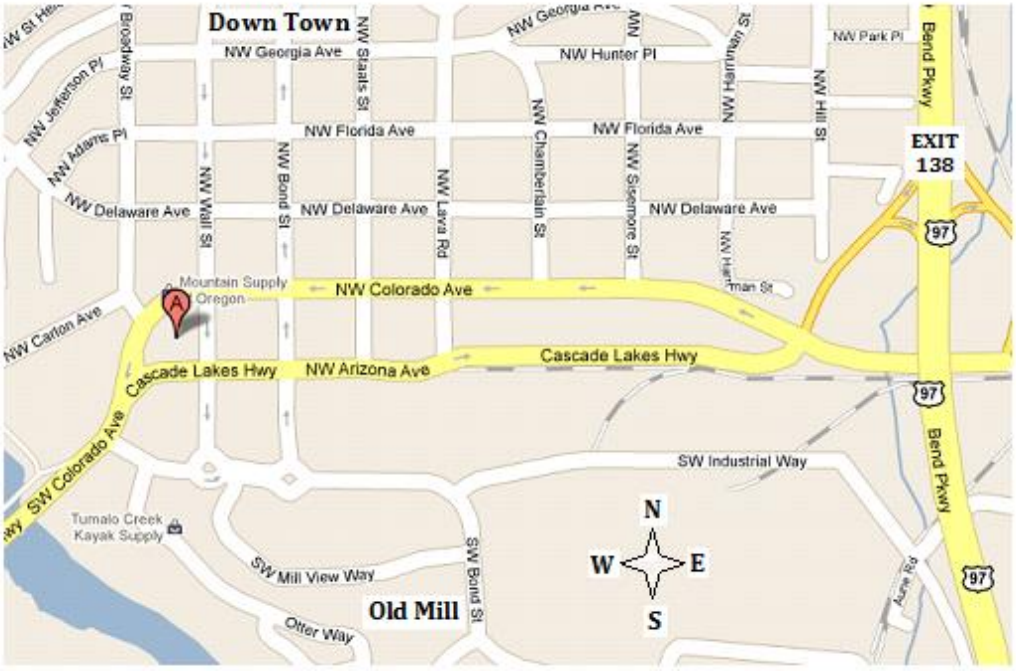
❒ Ensure that this packet has all 4 pages and that your paperwork is completely filled out and appropriate pages are signed and dated.

ARRIVAL TIME:

If paperwork is **NOT COMPLETE** please **arrive 5 minutes prior to scheduled arrival time**.

This is to ensure that we have time to input your paperwork in the computer. We strive to start your appointment with your therapist right on time.

AREA MAP



Please print out our "**Directions to Falling Waters**" page off of our website for more specific directions on how to get to our clinic or use your GPS with the address below.

MASSAGE THERAPY INTAKE

Remember to bring completed paperwork. (If paperwork not completed, arrive 5 min prior to appt.)

First Name: _____ MI: _____ Last Name: _____ SS# _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Sex: ☐ M ☐ F DOB: ____/____/_____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Do you have children: ☐No ☐Yes, if Yes, how many children: _____ What are their ages? _____

Occupation: _____ Employer: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you give permission for our office to update your general medical practitioner with the progress of your condition? Yes No

Name of Medical Doctor: _____ Who may we thank for referring you to us? _____

MEDICAL CLEARANCE

On your first visit to our office one of our physicians will review your paper work and discuss with you any health concerns you may have. This also allows the Doctor to evaluate for contraindications as well as give direction to the massage therapist so your massage is safe and you can receive maximum benefit.

INSURANCE INFORMATION

Insurance Companies often cover massage or manual therapy when the patient is under chiropractic or physical therapy care.
Would you like us to call your insurance company and see if these services are covered for future visits? ☐ Yes ☐ No

RESPONSIBLE PARTY INFORMATION

If you are the responsible party, mark "self" and move down to "Payment Information".
Person responsible for patient's charges: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

First Name: _____ MI: _____ Last Name: _____ SS#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F DOB: _____/_____/_____ Age: _____ Cell: _____ Work Phone: _____

Employer: _____ Occupation: _____

PAYMENT INFORMATION

Please check the following payment methods that apply: ☐ Health Insurance ☐ Cash ☐ Coupon/Gift Certificate
☐ This injury is related to a Work Injury. Date of Injury: ___/___/____.
☐ This injury is related to an Auto Accident. Date of Accident: ___/___/____.

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves a time for you and no one else. If you happen to miss an appointment or need to re-schedule / cancel with less than 24 hours' notice, we will allow for 2 occurrences as we know unexpected circumstances arise. On the 3rd time, we will change you to "day of" scheduling and will no longer be able to pre-reserve appointments for you. This policy will be explained further if this should apply. Thank you for giving us **24 hours' notice if you are unable to come to a scheduled appointment**.

I _____ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment**. I agree to allow Falling Waters, LLC and/or provider to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize Falling Waters, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I authorize payments to be made directly to Falling Waters, LLC and/or provider for treatment rendered. **I understand that co-payments and time of service fees are due at the time of service, I may receive an additional bill for services not covered by my insurance and any fees incurred by sending to collections will be added.**

Patient's Signature: _____ **Date:** _____
Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

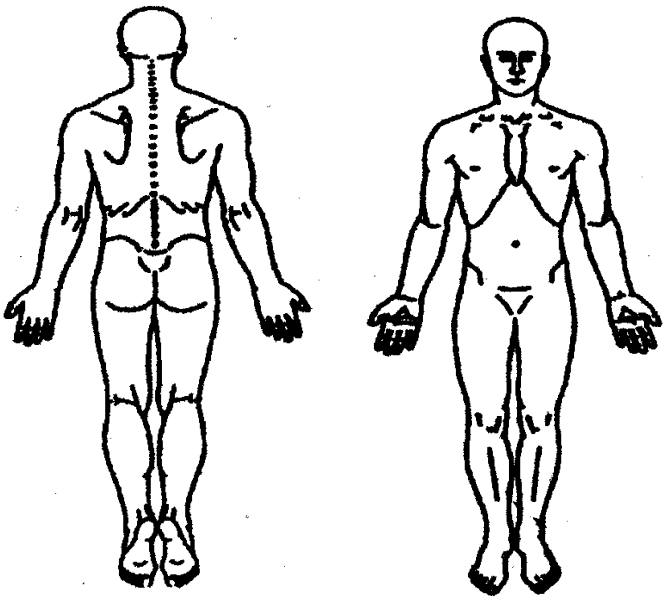
Tips to the Massage Therapists are never expected, if however you do wish to tip, please use Cash or Check and leave with Front Desk.

MASSAGE THERAPY GOAL FORM

1. What is your **goal** with massage therapy? _____
2. Is there any symptom/condition you specifically want massage therapy for? _____

Using the following abbreviations to indicate where you are experiencing symptoms

P = Pain **S** = Stiffness **A** = Aching **B** = Burning **NT** = Numbness / Tingling



3. When did your symptoms **begin**?

   _____

4. Did the symptoms begin **gradually** or **suddenly**? _____
5. Was there any **trauma** involved? **YES NO**

   If yes, describe:_____

   _____

   _____

6. Any **changes** in the following? **YES NO**

   If yes, check & describe:

   - ❑ Work duties
   - ❑ Hobbies
   - ❑ Exercise (new or changed)
   - ❑ Eating habits
   - ❑ Ergonomics
   - ❑ Lifestyle
   - ❑ Stress
   - ❑ Sleep patterns

7. Are the symptoms **constant** or tend to **come and go**? _____
8. How **often** do the symptoms bother you? _____
9. How **long** do the symptoms last for? _____
10. Do you have **pain at night**? **YES NO** Is the condition getting **progressively worse**? **YES NO**
11. Has this condition **bothered you before**? _____
12. How **severe** are your symptoms? **Mild Moderate Severe Unbearable**
13. Would you **describe** it as (circle): SHARP, SHOOTING, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPY, OTHER:_____
14. Does this condition **prevent** you from any **daily** or **recreational activities**? **YES NO**

    If yes, please describe: _____
15. What **aggravates** the condition? _____
16. What **relieves** it?_____
17. Are there any **other symptoms** that you can associate with this condition? **YES NO**

    If yes, please describe: _____
18. If not mentioned above, do you ever experience **foot** or **knee pain**? **YES NO**

19. Have **you** or **anyone** in your **immediate family** suffered from (circle):

You	Family		You	Family		You	Family	
❒	❒	Cancer	❒	❒	Heart disease	❒	❒	Neck pain
❒	❒	Arthritis	❒	❒	High blood pressure	❒	❒	Back pain
❒	❒	Aneurysm	❒	❒	Osteoporosis	❒	❒	Knee pain
❒	❒	Stroke	❒	❒	Diabetes	❒	❒	Foot pain
❒	❒	Skin condition	❒	❒	Depression	❒	❒	Other: _____

20. Have you ever had any **serious illnesses**? _____ Describe:_____

21. Have you ever had **surgery**? _____ Describe:_____

22. Have you ever been **hospitalized**? _____ Describe:_____

23. Any **major traumas**? (e.g. Falls, Car accidents, Work related injuries, Fractures?)_____

_____

24. Are you taking any **medications** or **contraceptives**? _____

25. Are you taking any **vitamins** or **herbs**? _____

26. Do you have any **allergies**? _____

27. Have you ever had spinal **X-rays, MRI or CT** scan? _____

28. When was your **last Physical exam**? _____ Outcome / concerns? _____

29. Do you **smoke**? _____ cig/day_____

30. Which of the following do you do at **work**:

❑ Sit	❑ Heavy lifting	❑ Repetitive motions
❑ Stand	❑ Prolonged postures	❑ Other:_____

31. What **form** of **exercise** you do on a <u>weekly</u> basis?

❑ Weights	❑ Jogging / walking	❑ Biking
❑ Aerobics	❑ Swimming	❑ Other:_____

32. How many hours do you **sleep** at night? _____ Do you feel **rested** in the morning? Yes / No

CERTIFICATE OF AUTHENTICITY

I hereby certify that the above information is true and correct within the best of my knowledge.

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

MUTUAL UNDERSTANDING & CONSENT TO TREATMENT
For Massage Therapy

The following information is provided to enable our sharing of common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please ask any questions if you would like clarification or additional information.

- Information revealed during massage therapy sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.

- All procedures and/or treatment carries with it both risk and benefits. Possible side effects from Massage therapy is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer positive experience of touch.

- The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. Massage therapy is not a substitute for care by a physician. It is recommended you concurrently continue to work with your doctor. Massage therapists are not trained to diagnose illness or disease, do not prescribe medication and spinal manipulation is not part of massage therapy sessions.

- There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and will be customized to your unique health status and your personal goals, no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s).

- Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.

- You are responsible for payment of treatment regardless of insurance coverage. As a courtesy, we provide insurance billing service. However, each insurance plan offers different levels of reimbursement and/or coverage for services. Many "preventative approaches" to healthcare are not covered by insurance plans. At your request, you will receive a detailed receipt to request reimbursement from your insurance carrier.

- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Consult your prescribing doctor before discontinuing medications. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments by other providers between visits.

- You are encouraged to ask questions on ay health-related topic and to take an active role in your health care. Ours is a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyles that can help you attain your highest level of health.

My signature below consents to treatment assures that the contact information, health history, and other information that I provide on my intake forms are complete and accurate. I understand and agree to the information on this page. I have read, understand and agree to the information in this intake packet and my questions, if any, were answered to my satisfaction.

CERTIFICATE OF CONSENT

My signature below consents to treatment and assures that the contact information, health history, and other information that I have provided on my intake forms are complete and accurate. I have read, understand and agree to the information in this packet and my questions, if any, were answered to my satisfaction.

Printed Name of Patient: _____

Signature of Patient: _____ Date: _____

Parent or guardian signature needed if patient under 18 *mm / dd / yyyy*

PROTECTED HEALTH INFORMATION DISCLOSURE

Name: _____ DOB: _____ Today's Date: _____

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

- My health information may be created or received by Falling Waters, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.
- We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.
- I understand that I have the right to receive and review a written description of how Falling Waters, LLC will handle my health information. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Falling Waters, LLC and my rights regarding my health information.
- I understand the Notice of Privacy Practices may be revised periodically and my health information will not be disclosed unless I have given written consent. I understand a copy of the most recent version of Falling Waters, LLC's Notice of Privacy Practices will be posted in the reception area.

By signing this agreement I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before you sign this consent.

Signed: _____ Date: _____

Special Permission Request:
I give my permission for Falling Waters, LLC to leave messages regarding appointments on my home/mobile telephone.

Signed: _____ Date: _____

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner, caregiver _____ _____ _____
Name of spouse/partner/caregiver | Date of birth | Telephone #

Signed: _____ Date: _____

This release will revoke by written permission only. I understand that I must send a written request to Falling Waters, LLC in order to revoke this release.

Signed: _____ Date: _____