Active Spines CHIROPRACTIC

Massage Intake Form

Name_____ Date_____

Address_____
Street City State Zip

Date of Birth_____ Home Number _____ Cell Number_____

Email:_____

Emergency Contact _____
Name Relationship Number

Are you presently taking any medication? _____Yes _____No

Please Explain:

_____

_____

Have you had a recent major surgical procedure or injury? ____ Yes ____ No

Please Explain:

_____

_____

Are you currently seeing a Chiropractor, Physical Therapist, or Physician for an ongoing issue?

____ Yes ____No

Please Explain:

_____

_____

Please circle your stress level:

Low 1 2 3 4 5 High

Are you allergic to any Lotions or Oils? ____ Yes ____ No

Please Explain:_____

Intake Form

Circle the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Skeletal

Headaches
Joint stiffness/swelling
Spasms/cramps
Broken/Fractured bones
Strains/Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Chest, ribs, abdominal pain
Problems walking
Jaw pain/TMJ
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Other:_____

Circulator/Respiratory

Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Stroke
Heart condition
Allergies
Asthma
High blood pressure
Low blood pressure
Other:_____

Digestive

Indigestion
Constipation
Intestinal gas/bloating
Diarrhea
Irritable bowel syndrome
Crohn's Disease
Colitis
Other:_____

Nervous System

Numbness/tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes/shingles
Cerebral Palsy
Epilepsy
Chronic Fatigue Syndrome
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Other:_____

Reproductive System

Pregnancy
Ovarian
Prostate
Other: _____

Skin

Rashes
Allergies
Athlete's foot
Acne
Impetigo
Hemophelia

Other

Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Post/Polio Syndrome
Cancer
Tuberculosis
Other:_____

I understand that a massage Therapist does not diagnose disease, illness, or prescribe any treatment or drugs, nor do they provide spinal manipulation. I understand that draping will be used at all times and that breast massage will not be administered on female clients. I understand that if I become uncomfortable for any reason that I may ask the Therapist to end the massage session, and they will end the session. I understand that the massage Therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform the health care provider of any changes in my status.

Client's signature_____ Date_____

Consent for Therapy and Waiver of Liability

The undersigned ("Client") hereby freely consents to receipt of massage services from:

Licensed Massage Therapist's Name

Client agrees as follows:

Client understands and agrees that they will provide the Therapist with complete and accurate health information, and a written referral from Client's primary healthcare provider if Client is currently receiving care or has a specific medical condition or symptoms for which Client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aid and is not suitable for primary medical treatment for any condition.

1. Client and Therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manually therapy for the predetermined goals of stress reduction, relief of muscular discomfort, and/or promotion of general health. Client has been given an opportunity to ask questions of the Therapist and has received all requested information.
2. Client understands that the unclothed body will be draped at all times for warmth, sense of security, and as a mark of massage therapy professionalism. Client agrees to immediately inform the Therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to Client's level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the client's part, will result in an immediate termination of the therapy session. Client understands that payment will be expected in full; regardless if the massage is completed or not.
3. Client hereby assumes fully responsibility for receipt of the massage therapy, and releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist , to the fullest extent allowed by law.
4. Client, in signing this consent for Therapy and Waiver of Liability ("Consent"), understands and agrees that this Consent will apply to and govern the current and all future therapy sessions performed by Therapist
5. **Cancellation Policy:** Your business is valued and your cooperation is appreciated .We are making a commitment to you to guarantee your appointment time and refusing all other requests once you have made the appointment. A **24-hour cancellation notice** is required for any scheduled appointments including gift certificate sessions. Missed or no-show appointments will result in your being charged **$30.00** no show fee unless the appointment can be filled. Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked: Full payment is required. Emergency cancellations are determined by the Massage Therapist discretion.

Client Signature	Client Printed Name	Date

Massage Therapist Signature	Massage Therapist Printed Name	Date

Financial Policy- Private Insurance

1. For those patient who are covered by private insurance, it shall be your responsibility to confirm the specifics of your insurance coverage as this is not a responsibility of our office.
2. Our clinic will be happy to bill directly to your insurance carrier provided that you are eligible for chiropractic care and the required medical services, and that we have your complete insurance information such as insurance company's name, address, telephone number, policy/claim number, etc. You will have to pay on the first visit the yearly deductible and the appropriate insurance copayment, if applicable, as services is rendered.
3. If your insurance company has not paid within 45 days after the billing date, our office reserves the right to bill the patient for the amount due. It shall be the patient's responsibility to deal with their respective insurance company when there is a question of the incorrect fee payments or non-payment for services rendered.
4. Accounts that are thirty (30) days past due are subject to a 1% finance charge per month, interests charge are payable on a monthly basis regardless of the type of the insurance coverage.

Agreement of Insurance Benefits & Authorization for Release

1. I agree and acknowledge that my signature on this document authorizes my physician to submit claims for payment of services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependants, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I, _____(Name of the Insured)/_____(Policy number) hereby assign to and authorize _____(Name of Insurance Company) to pay by check make out and mail directly to: Active Spines, Inc. all benefits if any, otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered. This payment shall not exceed my indebtedness to above mentioned assignee and I have agree to pay in a current manner, any balance of professional service charges over and above this insurance payment. This assignment is effective for any/all treatments received by me during the applicable year in which treatment is received. I also authorized Active Spines, Inc. to release any information required relating to all claims for benefits submitted on behalf of myself and/or dependant.
2. I clearly understand the above policy and agree that I am financially responsible for payment of services rendered to me and if my account is sent to a collection agency. I am responsible for any attorney fees incurred.
3. Our practice firmly believes in establishing excellent doctor/patient relationships, which are rooted in good communication and understanding. Missed appointments hinder that relationship. As a courtesy to Active Spines Chiropractic's patients and staff, please give 24-hour notice for all cancelled appointments if it is within your control. **No show or no call will result in a $30.00 charge.** We appreciate your consideration in this matter.

Patient: _____ Date: _____

Parent/Guardian: _____ Date: _____

Witness:_____ Date:_____

Treatment Record

Date	Client Remarks	Therapist Remarks	Session Length	Notes