balance
THERAPEUTIC MASSAGE + CORE FITNESS STUDIO

Massage New Client Registration

Please fill this form out completely so we can help you get fit for life!

Today's Date _____ Date of Birth _____/_____/_____

First Name _____ Middle Initial _____ Last Name _____

Address _____

City _____State _____ Zip Code _____ Marital Status S / M / D / W

Phone _____ H / W / C Alt. Phone _____ H / W / C

Email _____

Emergency Contact

Name _____ Relationship _____

Phone _____ Alternate Phone _____

Email and Phone Notifications

Balance Massage and Fitness occasionally sends email newsletters to our clients, with special promotions, schedule changes, clinic news, etc.

Would you like to receive these emails?	☐ Yes	☐ No
Would you like email confirmation of your scheduled appointments?	☐ Yes	☐ No
Would you like a reminder call before your scheduled appointments?	☐ Yes	☐ No

How did you hear about our practice? (Check all that apply)

☐ Google	☐ Facebook	☐ Health Fair or other Event
☐ Friend	☐ Another Client	☐ Whom may we thank? _____

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Patient Health Information

Patient Name_____
Today's Date _____ Date of Injury_____
Employer _____
Work Address _____
Occupation _____

Primary Health Care Provider

Name_____
Address _____
Phone_____Fax_____

I give my Licensed Massage Thrapist permission to consult with my health care providers regarding my health and treatment.

Comments_____
Initials_____ Date_____

Current Health Concerns check all that apply

Primary_____

☐ mild	☐ moderate	☐ disabling
☐ constant	☐ intermittent	
☐ getting worse	☐ getting better	☐ no change
☐ symptons	↑ w/activity	↓ w/activity

Treatment received _____

Secondary_____

☐ mild	☐ moderate	☐ disabling
☐ constant	☐ intermittent	
☐ getting worse	☐ getting better	☐ no change
☐ symptons	↑ w/activity	↓ w/activity

Treatment received_____

Additional_____

☐ mild	☐ moderate	☐ disabling
☐ constant	☐ intermittent	
☐ getting worse	☐ getting better	☐ no change
☐ symptons	↑ w/activity	↓ w/activity

Treatment received_____

Daily Activities Limited by Condition

Work _____
_____
Home/Family_____
_____
Sleep/Self-care_____
_____
Social/Recreational_____
_____

Self-Care Routines

How do you reduce stress? _____
_____
How do you reduce pain? _____
_____
List all current medications (including pain relievers and herbal remedies)_____
_____
Have you ever received massage therapy before? _____ Frequency? _____
What are your goals for your massage treatment?_____
_____

Health History

Lisat and explain. Include dates and treatment received.

Surgeries_____
_____
_____
Injuries_____
_____
_____
Major Illnesses_____
_____
_____

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Patient Health Information

General

Current Past Comment

- ☐ ☐ headaches_____
- ☐ ☐ pain_____
- ☐ ☐ sleep disturbances _____
- ☐ ☐ fatigue_____
- ☐ ☐ infections_____
- ☐ ☐ fever_____
- ☐ ☐ sinus_____
- ☐ ☐ other_____

Skin Conditions

Current Past Comment

- ☐ ☐ rashes_____
- ☐ ☐ athlete's foot, warts _____
- ☐ ☐ other_____

Muscles and Joints

Current Past Comment

- ☐ ☐ rheumatoid arthritis_ _____
- ☐ ☐ osteoarthritis_____ _____
- ☐ ☐ osteoporosis_____ _____
- ☐ ☐ scoliosis_____
- ☐ ☐ broken bones_____
- ☐ ☐ spinal problems_____ _____
- ☐ ☐ disc problems_____ _____
- ☐ ☐ lupus_____
- ☐ ☐ TMJ, jaw pain_____ _____
- ☐ ☐ spasms, cramps_____
- ☐ ☐ sprains, strains_____ _____
- ☐ ☐ tendonitis, bursitis__ _____
- ☐ ☐ stiff / painful joints__ _____
- ☐ ☐ weak / sore muscles_ _____
- ☐ ☐ neck/shoulder/arm pain_____
- ☐ ☐ low back/hip/leg pain _____
- ☐ ☐ other_____

Nervous System

Current Past Comment

- ☐ ☐ head injury/concussion _____
- ☐ ☐ dizziness, ringing in ears _____
- ☐ ☐ memory loss, confusion _____
- ☐ ☐ numbness, tingling___ _____
- ☐ ☐ sciatica, shooting pain _____
- ☐ ☐ chronic pain _____
- ☐ ☐ depression_____
- ☐ ☐ other_____

Respiratory, Cadiovascular

Current Past Comment

- ☐ ☐ heart disease_____ _____
- ☐ ☐ blood clots_____
- ☐ ☐ stroke_____
- ☐ ☐ lymphedema_____
- ☐ ☐ high, low blood pressure _____
- ☐ ☐ irregular heart beat___
- ☐ ☐ poor circulation_____
- ☐ ☐ swollen ankles_____
- ☐ ☐ varicose veins_____
- ☐ ☐ chest pain, shortness of breath_____
- ☐ ☐ asthma_____
- ☐ ☐ other_____

Allergies

Current Past Comment

- ☐ ☐ scents, oils, lotion_____ _____
- ☐ ☐ detergents_____
- ☐ ☐ other_____

Digestive / Elimination system

Current Past Comment

- ☐ ☐ bowel problems_____
- ☐ ☐ gas, bloating_____
- ☐ ☐bladder/kidney/prostate _____
- ☐ ☐ abdominal pain_____
- ☐ ☐ other_____

Endocrine, Reproductive System

Current Past Comment

- ☐ ☐ thyroid_____
- ☐ ☐ diabetes_____
- ☐ ☐ pregnancy_____
- ☐ ☐ painful menses_____
- ☐ ☐ fibrotic cysts_____
- ☐ ☐ other_____

Cancer / Tumors

Current Past Comment

- ☐ ☐ benign_____
- ☐ ☐ malignant_____

Habits

Current Past Comment

- ☐ ☐ tobacco_____
- ☐ ☐ alcohol_____
- ☐ ☐ drugs_____
- ☐ ☐ caffeine_____

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Current Fee Schedule

Wellness Massage Packages
(S5190)

Wellness Massage	Single 30-minute	$32.50
	Single 60-minute	$65.00
	Single 90-minute	$97.50
	Single 2 Hour	$130.00

Wellness or relaxation Massage is not a covered benefit under most insurance plans and will not be billed.

Therapeutic Massage
(97124)

Group Co-pay	
Kaiser/CHP	$15.00/$25.00
Providence	$15.00
ASH/HealthNet	$15.00/$25.00/Ded/Co-ins

Fee schedule as of 1/1/2019, prices are subject to change

Are you covered under a Group Contract Plan? ___ If so, please provide a copy of your Health Insurance card.

I am currently a patient of Active Chiropractic and Rehabilitation ☐
I am currently under the care of the following Physician _____

We accept cash, checks, visa and master cards as form of payment. This fee schedule is subject to change at any time, and any changes will be posted in advance in the studio.

_____ _____
Signature of patient or parent / legal guardian Date

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FINANCIAL AGREEMENT

- ☐ **SELF PAY/CASH**: Payment is due at the time of service. All cash patients will receive a "Time of Service" (TOS) discount. A detailed statement/receipt will be provided to the patient at their request for submission to any third parties for patient reimbursement.
  _____ I understand that payment is due at the time of service.
- ☐ **AUTO INSURANCE**: If your injuries were sustained in a motor vehicle accident, your medical expenses are covered by any Personal Injury Protection (PIP) coverage of the vehicle you were in. We will submit bills on your behalf to the PIP insurance of the vehicle you were in, as is our office policy and according to the Oregon Statutes. We will not bill the PIP coverage of the other vehicle. You must complete and submit the PIP Benefits Application supplied by the insurance company in order for medical expenses to be paid to this office. Any medical expenses not covered or denied become the responsibility of the patient. Additionally, it is our office policy **not** to forward any denied or non-covered charges to group medical insurance for payment.
  _____ I understand/agree that I am responsible for all charges; whether or not they are payable by insurance. I understand that if my PIP coverage has reached its maximum, I am fully responsible for any and all charges not covered by my insurance and that these non-covered/denied charges will not be forwarded to my group insurance policy.
- ☐ **WORKERS COMPENSATION INSURANCE**: If your injuries were sustained in a work-related incident, your medical expenses are covered by your employer's Workers Compensation Insurance once your claim has been accepted. Any medical expenses not covered or denied become the responsibility of the patient. Additionally, it is our office policy **not** to forward any denied or non-covered charges to group medical insurance for payment.
  _____ I understand/agree that I am responsible for all charges; whether or not they are payable by insurance.
- ☐ **MEDICAL/HEALTH INSURANCE**: Any copay. deductible or co-insurance percentage agreement you have with your medical/health insurance are due at the time of service. Our office will provide you with an estimate of your financial responsibility for each appointment. We will make our best effort to provide you with a list of non-covered services. Any medical expenses not covered or denied become the responsibility of the patient, unless prohibited by our contract with the insurance.
  _____ I understand/agree that I am responsible for all/any copay. deductible or co-insurance percentage and all charges, whether or not they are payable by insurance.
- ■ Credit Terms are 30 days from date of invoice. Outstanding balances are subject to 1.5% per month interest. The undersigned authorizes and releases all banks, persons, and companies listed on this application to furnish information and authorizes the checking of credit. The undersigned agrees to pay all collection costs, court costs, and legal fees incurred to collect delinquent balances.

PATIENT/GUARDIAN _____DATE_____

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Waiver of Liability and Informed Consent

This form is an important legal document. It is critical that you read and understand it completely.

I, _____, understand that I have voluntarily enrolled in a program of manual therapy including, but not limited to massage, under the direction of Balance Therapeutic Massage and Core Fitness Studio (BTMCFS), and I give my consent to receive said treatment. I hereby affirm that I am in good physical condition and do not suffer from any disability that would prevent or limit my participation in this program. I understand and agree that it is my responsibility to inform BTMCFS of any changes (including pregnancy) to my physical health.

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my interpretation of that information. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Indemnification and Hold Harmless: In consideration of my participation in the BTMCFS manual therapy treatment program, I do hereby and forever release, waive , discharge and hold harmless BTMCFS and its respective agents, heirs, assigns, contractors and employees from any and all claims, demands, damages and causes of action, present or future, arising from my participation in the BTMCFS manual therapy treatment program, including, but not limited to, any and all claims, demands and causes of action made as a result of the negligence of BTMCFS, its agents, employees or contractors. I hereby release BTMCFS from any liability now or in the future with respect to any injuries I may incur, however caused, occurring during or after my participation in the BTMCFS manual therapy treatment program.

I understand that results of any manual therapy treatment are individual and may vary, and I therefore acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I hereby affirm and acknowledge that I have read and full understand this release of liability and assumption of risk. I also affirm and acknowledge that I am signing this agreement freely and voluntarily.

To be completed by the patient or patient's representative, if necessary (e.g. if the patient is a minor or physically or legally incapacitated).

_____	_____
Print name	Print name of patient's representative
_____	_____
Signature of patient	Signature of patient's representative
_____	_____
Date	Relationship to patient or authority of representative

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No-Show / Late Cancellation Policy

Quality care for our patients is our priority. Please take a few minutes to review our policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a "No Show / Late Cancellation"

Active Chiropractic and Rehabilitation defines a "No-show" appointment as any scheduled appointment in which the patient either:

- ✓ Does not arrive to the appointment
- ✓ Cancels with less than 24 hours' notice (excluding holidays and weekends)

Impact of a "No-Show" Appointment

"No-show" appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient "no-shows" a scheduled appointment it:

- Potentially jeopardizes the health of the "no-showing" patient
- Is unfair (and frustrating) to other patients that would have taken the appointment slot
- Impacts the daily flow of the clinic team and providers

How to Avoid Getting a No Show / Late Cancellation Status

- ✓ **Opt In** for Appointment reminders (calls and/or texts)
- ✓ Arrive 10 minutes early
- ✓ Give **24 hours'** notice to cancel appointment (excluding holidays and weekends)

1. Opt In for reminder calls and/or texts
   Active Chiropractic and Rehabilitation will make a reminder call or text you two business days before your scheduled appointment. This is a courtesy service many busy patients elect to have provided.

2. Always Arrive 10 Minutes Early
   When you schedule an office visit with us, please plan to arrive 10 minutes prior to your scheduled appointment time. This allows time for you and our team to address any insurance or billing questions and or to complete/update any necessary paperwork before your appointment.

3. Give 24 Hours' Notice if You Need to Cancel/Reschedule
   When you need to cancel or rebook a scheduled appointment, please contact our office at least 24 hours' (excluding holidays and weekends) before the appointment. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care as well as giving us the opportunity to rebook the now vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call. (We understand that emergencies do happen and consideration may be given and fee waived.)

Consequences of a No Show / Late Cancellation Status

- ✓ **A $50 "No Show/Late Cancellation" fee will be applied to your account.**
- ✓ If you miss 3 or more appointments within a year you may be dismissed from the clinic. Patient dismissal is at the discretion of your provider and management.
- ✓ If you are dismissed from the clinic, your remaining scheduled appointments will be cancelled.
- ✓ Reapplication to the clinic after a six month period after initial dismissal letter will be considered by your provider and management.

I have read and understand the Active Chiropractic and Rehabilitation "No Show" policy as described above.

Signature & Date

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Receipt of Privacy Notice

- ☐ I have received and/or reviewed a copy of NOTICE OF PRIVACY PRACTICES
- ☐ I consent to having detailed messages regarding my account or appointments left on my voicemail.
- ☐ I do not consent to having detailed messages regarding my account or appointments left on my voicemail.

Comments, if any:

_____

_____

To be completed by the patient or patient's representative, if necessary (e.g. if the patient is a minor or physically or legally incapacitated).

_____ _____

Print name | Print name of patient's representative

_____ _____

Signature of patient | Signature of patient's representative

_____ _____

Date | Relationship to patient or authority of representative

_____ _____

Signature of Health Care Practitioner | Date