Atlas Chiropractic, Massage & Wellness Center - 2228 James St. Bellingham, WA 98225 - 360-527-1030

Massage Therapy Treatment

Contacts Information

Name: _____ Date of birth: _____ Sex: ☐ M ☐ F

Home Phone: _____ Cell Phone:_____ Email:_____

Address: _____ City: _____ State:_____

Zip:_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Social Security:_____

Occupation: _____ Employer: _____

Spouse Name: _____ Spouse Employer: _____

Emergency Contact (Name, Phone, Relation): _____

How were you referred to this office: _____

Current Health Condition

Purpose of this appointment: ☐ Relaxation ☐ Specific focus: _____ ☐ Other:_____

This condition is: ☐ Job Related ☐ Auto Accident ☐ Sports Injury ☐ Chronic ☐ Other:_____

When and how did it begin? _____

Has this condition occurred before? ☐ Yes ☐ No If Yes, when? _____

What treatment or activities make it better? _____

What treatment or activities make it worse? _____

Condition is: ☐ Getting Better ☐ Getting Worse ☐ Staying the Same

Condition interferes with: ☐ Work ☐ Sleep ☐ Daily Activities ☐ Other:_____

Other healthcare providers seen for this condition: _____

Names of other healthcare providers: _____

May we contact your other healthcare providers if necessary? ☐ Yes ☐ No

Other healthcare providers contact information: _____

Medications and/or supplements taken:_____

Major Surgeries and/or hospitalizations: _____

Any questions or concerns:_____

Please circle and briefly describe any areas of discomfort or complaints :

_____

_____

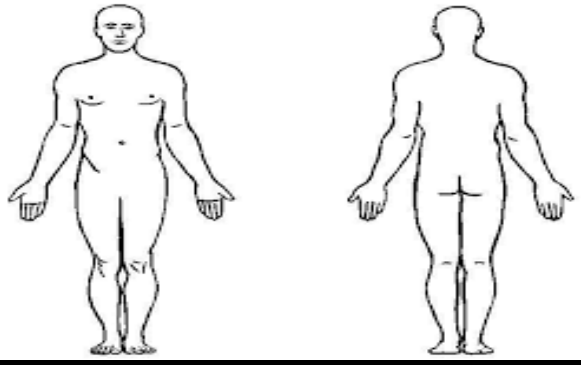
_____

_____

_____

_____

_____



Health History

Please check each of the diseases or conditions that you are experiencing now or have experienced in the past. Information here will help the massage therapist in determining how massage can best help you and will aid in providing a safe massage for you.

- ☐ Headaches
- ☐ Dizziness
- ☐ Loss of sleep
- ☐ Pain between shoulders
- ☐ Frequent neck pain
- ☐ Numbness or pain in arms/legs/hands
- ☐ Lower back problem
- ☐ Heart attack/stroke
- ☐ High blood pressure
- ☐ Arthritis
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Hepatitis
- ☐ Cancer
- ☐ Rheumatic fever
- ☐ Psychiatric problems
- ☐ Thyroid problems
- ☐ Contagious Disease: _____
- ☐ Skin Condition: _____
- ☐ Allergies: _____ _____
- ☐ Pregnancy (Due date): _____
- ☐ Other: _____ _____

Why Massage?

Massage can be used for a variety of different reasons and there are different types of care. To help the massage therapist best serve your treatment goals, please check which type of care you are seeking.

- ☐ Relaxation
- ☐ Pain Relief: Get rid of pain, short-term relief
- ☐ Corrective: Get rid of pain and make recommendations to fix the problem
- ☐ Optimal Health: Get rid of pain, make recommendations to fix problem and to maintain my-best possible health
- ☐ I'm not sure, please help me to understand my options

Financial Policy and Patient Serviced Agreement

Who is responsible for your bill? ☐ You and: ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Health Insurance

In order to receive the best care possible within your maximum benefits, it is important that you comply with our financial policy:

1. Payment is expected at the time of service in the form of a deductible, co-payment, or co-insurance payment. It is illegal to waive these fees.
2. Your policy is a contract between you and the insurance company and you are responsible for any unpaid or denied claim and for any collection fees, court costs, and attorney's fees if your account is turned over for collections.
3. If your insurance company sends you checks, it is your responsibility to deliver them to our office within 5 (five) days.
4. Affordable payment plans are available in special cases.
5. Cancellations made with less than a 24 hours' notice will be charged a $50 late cancellation fee. This fee will not be covered by your insurance group, worker's comp, or any 3rd party payer.
6. If you do not show up to your scheduled appointment you will be charged a $50 no-show fee. This fee will not be covered by your insurance group, worker's comp, or any 3rd party payer.

"I hereby authorize Atlas Chiropractic, Massage & Wellness Center to furnish information to my insurance company concerning my care. I further hereby assign all insurance payments for massage services rendered to me or my dependents by Atlas Chiropractic, Massage & Wellness Center, to Atlas Chiropractic, Massage & Wellness Center."

I, _____ have read and fully understand the above statements.

Signature: _____ Date: _____

Terms of Acceptance

I have completed this health intake to the best of my knowledge. I understand that massage therapy is a therapeutic health aid and not intended to replace a physician's care when needed. Any procedure beyond the therapist's scope of practice including diagnosis will be referred to the proper health care provider. All information discussed during the massage session is confidential and will be shared with other health care providers solely for the purpose of my health care.

The office's massage policies have been made available for me to read. I understand I may request a copy of this policy for my own records. I agree to adhere to both the cancellation and late appointment policies.

I understand that all insurance coverage, whether accident, work-related, or general coverage, is an arrangement between my insurance carrier and myself. Any insurance billed by this office is done so as a convenience and I am ultimately responsible for any balance unpaid or denied by my insurance company.

I, _____ have read and fully understand the above statements.

Signature: _____ Date: _____

Consent to evaluate and treat a minor child

Parents/Legal Guardians, please complete: I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive massage care.

Signature: _____ Date: _____