Massage Therapy Patient History

PLEASE **PRINT** CLEARLY

Today's Date: ______________ Patient Number: ___________

Name: ____ Preferred Name: ____________________________

Address: __________________________________ City: ____________________ State: _____ Zip: ___________

Home Phone: _________________ Cell Phone: ____________________ Work Phone: ____________________

Date of Birth: ______________________ Age: _________ SSN: _________________________ Gender: M F

Do you have insurance that may provide massage coverage? Yes No

Insurance Policy Holder's Name and Date of Birth: ____

Major Complaint/s: ____

____ Date Began: _____________________

How did condition begin? ____

Is it getting worse? Yes No Have you lost work/school days? ◻ Yes ◻ No How many? _________

Have you had a similar condition before? ◻ Yes ◻ No If so, when? _______________________________

Is this injury related to: ◻ work accident ◻ auto accident

Current medications: ____

Allergies: ____

Surgeries: ____

Please check all that apply:

Heart conditions ◻	High/low blood pressure ◻	Fainting or dizziness ◻
Varicose veins ◻	Phlebitis/circulatory problems ◻	Headaches or migraine ◻
Neck injury ◻	Back injury ◻	Jaw or ear pain ◻
Osteoporosis ◻	Rheumatoid arthritis ◻	Osteoarthritis ◻
Cancer ◻	Kidney disease ◻	Skin conditions ◻
Diabetes ◻	Asthma/respiratory ◻	Fibromyalgia ◻
Crohn's disease ◻	Pelvic inflammatory disease ◻	Epilepsy ◻
Nervous disorders ◻	Whiplash ◻	Seizures ◻
Bruise easily ◻	Pregnant ◻ _____ weeks	Other:

Informed Consent for Massage Therapy Treatment

I understand that my massage therapist is licensed in the state of Colorado and is providing massage therapy services at Crossroads Family Chiropractic within that scope of practice. If I experience pain or discomfort during the session, I will inform the therapist so that necessary adjustments can be made. I understand that massage is not a replacement for medical care and that no medical diagnosis will be made.

I understand that any illicit or sexually suggestive comments or actions made by me will result in immediate termination of my session. Should this occur, I will be responsible for full session charges and I will be unable to schedule future appointments.

Because massage should not be performed under certain medical circumstances, I understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form and disclosed all medical conditions affecting me. It is my responsibility to keep the therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge. I understand that the therapist reserves the right to refuse to perform massage on anyone with a condition for which massage is contraindicated.

By signing this form I confirm my consent to treatment. I understand that I may withdraw my consent at any time, at which point treatment will be stopped.

Please feel free to discuss our fees and ask about our discounted prepaid plans. Fees are payable when services are received. By your signature you state that you understand that you will be responsible for all fees and costs associated with collection including attorney fees & court costs. Any unpaid balance will accrue a monthly late fee of $25.00.

A $30.00 fee may be assessed for any cancellation for which we do not receive a 24-hour notice.

Other than infants restrained in car seats or similar devices,
children are not allowed in the massage rooms while a parent is being treated.

Signature: ____ Date: __________________________

Printed Name: ____ File Number: ____________________

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. This form is a "friendly" version of the privacy practices. A more complete text is posted in our office and is available for your review.

A brief explanation: There are rules and restrictions regarding who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services (www.hhs.gov).

Crossroads Family Chiropractic has adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to contact patients regarding missed appointments and to remind them of upcoming massage appointments. We may do this by telephone or email. We may send you other communications informing you of changes to office policy by U.S. mail.

3. This practice utilizes a number of vendors in the operation of business. These vendors may have access to PHI but must agree, in writing, to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents that may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your PHI and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

____ _______________________

Signature (or parent/guardian of minor) Date

____ _______________________

Printed Name File number

Continued on next page…

Protected Health Information Release

PLEASE FULLY COMPLETE AND SIGN

At times we may need to contact you by telephone to discuss an appointment or health information. In order to protect the privacy of your information, we need to know how you would like to be contacted by our office staff or doctors.

Home number ___________________________
□ Use this number first
□ OK to leave a detailed message
□ Leave a call back number only

Work number ___________________________
□ Use this number first
□ OK to leave a detailed message
□ Leave a call back number only

Cell number ___________________________
□ Use this number first
□ OK to leave a detailed message
□ Leave a call back number only
□ Message appointment reminders may be sent via text messaging
Cell carrier: ___________________________

Email ___________________________
□ Use this method first

If you would like to allow us to provide messages or information to another party, please indicate that below. Information may be shared with the following person(s):

Name of Person	Relationship to Patient	Information you do not wish to be shared – please be specific.

□ I choose not to authorize disclosure to anyone. (Please initial the following statements)
I understand that by choosing not to authorize disclosure to anyone, this means that:
Only I am authorized to confirm, schedule, or change appointments. ______
Only I am authorized to receive account information or make payments on my account. ______
No information regarding treatment or even confirmation of status as a patient will be disclosed to any individual, regardless of personal relationship. ______

This authorization is effective through (check one):
□ ______/______/_______ □ NO EXPIRATION (unless revoked)

____ ___________________
Patient Name File number

____ ___________________
Signature of Patient or Personal Representative Date

____
Description of Personal Representative's Authority