Cascade
CHIROPRACTIC &
NATURAL MEDICINE

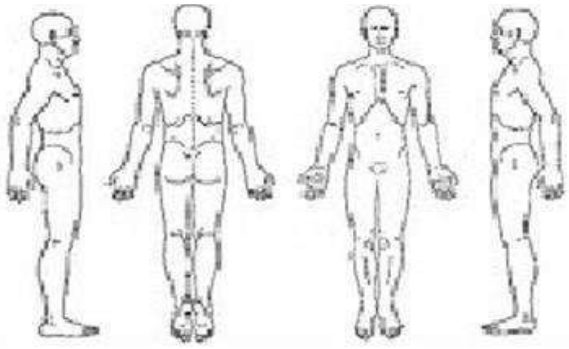
Massage Intake Form

Name _____ Date _____
Phone (C/W) _____ Email _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Occupation _____
Emergency Contact _____ Phone _____

What is the reason for your visit today? _____

When did symptoms start? _____

Y N Is this due to an accident or injury?
Y N Have you had a professional massage before?
Y N Do you have any difficulty lying on your front, back, or side?
Y N Are you currently under medical supervision?
If yes, please explain _____
Y N Are you currently taking any medication?
If yes, please list _____
Y N Are you pregnant? If so, how many months? _____



Circle any specific areas you would like the massage therapist to concentrate on during the session

Please check any condition listed below that applies to you:

- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ easy bruising
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains/strains
- ☐ current fever
- ☐ decreased sensation
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ phlebitis/deep vein thrombosis/blood clots/varicose veins
- ☐ osteoporosis
- ☐ joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis
- ☐ atherosclerosis/circulatory disorder
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ TMJ
- ☐ back/neck problems
- ☐ high or low blood pressure

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

_____

_____

_____

Draping will be used during the session – only the area being worked on will be uncovered.
Informed written consent must be provided by parent or legal guardian for any client under the age 17.

I, _____(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the Licensed Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

FINANCIAL POLICY

Patients not billing insurance:

- 100% of the visit cost is to be paid in full at the time services are rendered.
- For your convenience, our office accepts cash, check, and credit card payments.

Patients billing insurance:

_____ ***INITIALS NEEDED*****: Our office needs any and all insurance information from you prior to receiving treatment, even if you don't believe that one of the insurance carriers will pay for services rendered. Your insurances are aware of other carriers and this affects the processing of your claims. Some carriers require referrals and prior authorizations prior to treatment in order for them to be payable. By signing this financial policy, you are agreeing to provide us with all insurance information. If you don't provide us with required information to bill your insurance(s) (including but not limited to DMAP/OHP and Pacific Source Community Solutions, MODA and Regence), you are thereby taking responsibility for the payment of those services. If your insurance coverage changes during the time you receive care at our office and services are not paid by your insurance(s) as a result of not informing our office, you will be financially responsible for paying for the services rendered.**

- After verification of your coverage, we will accept payments directly from your insurance carrier.
- Patients are responsible for all uncovered services at the time of the visit, such as copay, co-insurance and deductible amounts.
- Patients must stay current with their patient responsibility balance.
- After all insurance claims have processed, we will reimburse you if you made an overpayment.
- Our office gives an insurance company 90 days from an incurred charge to pay their portion. If for any reason they do not pay in 90 days, then the balance becomes the patient's responsibility and is payable at that time.
- Your insurance is an agreement between YOU and your insurance company. Therefore, this clinic does not guarantee that your insurance company will pay the charges and will not enter into a dispute with the insurance company over reimbursement. If your insurance carrier denies a payment, the patient is personally responsible for payment. Verification of coverage is not a guarantee of payment for services rendered.
- Patient must notify our office if there are any changes to their insurance coverage while receiving care at our office. Failure to do so may result in lack of payment from their Insurance(s) and will be the patient's financial responsibility.
- The patient is responsible for any and all attorney fees for collection of past due accounts.
- Our office requires 24 hour notice when canceling an appointment. If less than 24 hour notice is provided, a $25 fee will be charged. If a patient reschedules with less than 24 hour notice or no show two times for an appointment, any appointment thereafter will need to be scheduled and rendered on the same day only.
- Our office provides appointment reminders via SMS texting/voice services and by signing this form, you consent to the fees associated by your phone carrier to process these communications. If a patient wishes to opt out of this service in the future, they need to provide written notification to our office.

I agree to the above listed terms set forth by Cascade Chiropractic & Natural Medicine.

_____ _____

Signature **Date**

NOTICE OF PRIVACY PRACTICES

This Notice explains how our office may use and disclose your protected health information and your rights regarding how we protect your health information. "Protected health information," including demographics, can be reasonably used to identify you, relates to your past, present or future physical or mental health condition, the provision of care to you, or the payment for that care. We reserve the right to change the terms of this Notice and our privacy policy at any time. Any changes will apply to all protected health information that we maintain effective the date of a new Notice. New Notices will be posted at Cascade Chiropractic and Natural Medicine clinic and you may obtain one at any time. This Notice goes into effect January 1, 2010.

Uses and Disclosures

We may use and disclose your health information for different reasons.

- **Treatment:** To assist in your diagnosis and treatment.
- **Payment:** In order to bill and collect payment for services provided. For example, to claims processing companies, others that participate in the claims payment process and your health insurance plan to get reimbursed for services.
- **Health Care Operations:** For activities necessary such as quality management, utilization review, anti-fraud and claims payment, provider credentialing activities, and as required by industry or government regulators such as state licensing boards, insurance regulatory agencies, and the sponsor of your health plan. Our office may not use or disclose any more of your protected health information than is necessary to accomplish the purpose of the use or disclosure, except for treatment purposes.

We must disclose, when required by law, for the following examples:

- **Avoid threat to health or safety.** To law enforcement personnel or persons able to prevent or lessen a serious threat to public safety.
- **Coroners, Funeral Directors, Organ Donation.** To said professionals such that they can carry out their duties.
- **Health oversight activities.** To assist the government agencies, such as when it conducts an investigation or inspection of a health care organization.
- **Health-related benefits or services.** For appointment reminders or to give you information about treatment alternatives or services that may be of interest to you.
- **Law Enforcement, judicial and administrative proceedings.** In response to a subpoena, discovery request, in response to a warrant, to identify or locate a suspect, to provide information about a victim of a crime, or other lawful process.
- **National security and intelligence.** As required by military officials for security and military purposes.
- **Public health activities.** To public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of abuse, neglect or domestic violence.** To government agencies and law enforcement personnel as required by law.
- **Workers' compensation.** In compliance with workers' compensation laws.

Authorization

Any uses or disclosures other than those described above will be made **only** with your prior written authorization, unless otherwise permitted or required by law. In the event that you authorize us to use your protected health information for other uses, you have the right to revoke any authorization by delivering a written revocation statement, except to the extent that we have already disclosed the information or are allowed by law to use the information to contest a claim or coverage.

NOTICE OF PRIVACY PRACTICES

Patient Rights

- **Right to request restrictions on uses and disclosures:** To request a restriction, please write a request to Cascade Chiropractic and Natural Medicine. Upon receiving your request, we will put the limits and terms in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required to make.
- **Right to receive confidential communications:** This includes the right to direct where communications are sent. For example, you may request that information be sent to our work address rather than your home address or via e-mail than by regular mail. To verify or modify where or how you would like communication sent, contact Cascade Chiropractic and Natural Medicine. Unless requested otherwise, we will direct mailings and telephone messages to the address/telephone number we have on record.
- **Right to inspect and copy.** Includes the rights to see and get copies of your information that we maintain. Submit your request in writing to Cascade Chiropractic and Natural Medicine and we will respond to you within 30 days of receipt of your written request. We will charge you a $10 copying fee and mailing costs but will inform you of that fee in advance.
- **Right to amend:** If you believe there is a mistake or missing information, you have the right to request that we correct or add to your file. You must provide the request in writing to Cascade Chiropractic & Natural Medicine. We will respond within 60 days of receipt of your written request. We may deny your request in writing if your information is 1) correct and complete, 2) not created by us, 3) not allowed to be disclosed, or 4) not part of our records. Upon approval, we will make the changes, inform you when the changes are complete, and inform others that need to know about the change in a timely manner. Our written denial will state the reason for the denial and explain your right to file a written statement of disagreement with the denial. You also have the right to request that copies of your initial request and our denial be attached to all future disclosures of your information.
- **Right to receive an accounting of disclosures.** This will not include uses or disclosures made for treatment, payment or health care operations, disclosures made directly to you, those you have already authorized, those made for national security reasons or to law enforcement that has lawful custody over you. We will respond within 60 days of receiving written request. Please include the time period for which you want the accounting. The accounting will include the date of the disclosure, to whom information was sent, a brief description of the information disclosed, and a brief statement of the purpose for the disclosure. We will provide the first accounting at no charge. For additional accountings, we may charge you a fee but will inform you of that fee in advance.
- **Right to get a paper copy of this Notice.** At any time even if you previously agreed to receive an electronic copy.
- **Right to file a complaint.** If you believe your health information has been improperly used or disclosed, or that your privacy rights have been violated, you may file a privacy complaint with us. Contact Cascade Chiropractic and Natural Medicine to file a complaint. You also have the right to file a complaint with the Secretary of the US Department of Health and Human Services. We will take no retaliatory action against you if you file a complaint with us or the DHHS.

I acknowledge having carefully read this copy of the Notice of Privacy Practices.

_____ _____

(Print Name) (Date)

_____

(Signature)

Note: If this acknowledgement is being signed by a legal representative, you must provide a copy of the power of attorney or other relevant document(s) designating you as the legal representative.

CASCADE CHIROPRACTIC & NATURAL MEDICINE OFFICE POLICIES

Please take the time to read our office policies to ensure that you have the best possible experience receiving care at our office. If you are not able to comply with these policies, you will be dismissed as a patient at our clinic.

1. **We strictly enforce our no show and cancellation policy.** For us to continue to be open for business, we need our patients to show up for their appointments and give us at least 24 hours notice if they need to cancel so we have time to fill that appointment time. If you don't show up or cancel with less than 24 hour notice, you will be required to schedule on the same day for appointments moving forward. If you are placed on same day scheduling, this means that if there is a day what works for you to make it to an appointment, you call our office that morning to see if there are any available appointment times.

2. **We expect patients to treat our staff with respect.** Our staff is expected to treat all patients with respectful and courteous behavior and we expect patients to treat our staff with the same respect and behave in a polite manner. If this expectation is violated, we have the right to terminate the doctor-patient relationship.

3. **You need to inform us of ALL insurances that you have.** In order for us to successfully bill insurance, you need to provide us with all of your insurance information. If insurance changes for you, you are required to let us know. If you fail to provide us with all insurance information and as a result we are not able to bill your insurance for payment, you will be responsible for the cost of the care you receive. Also, if you have more than one insurance you need to be sure to let all companies know of the other insurance you have. Insurance companies run periodic audits on their customers so they will find out eventually and require us to refund them. If that happens, you will be responsible for the cost.

4. **We require that all patients come to our office freshly showered and free of odor** to all visits due to the high volume of patients and staff with environmental sensitivities. Refrain from the following odors:
   - Cigarette smoke
   - Body odor
   - Perfumes

   If you are not able to do this, we will not be able to provide care for you. We know that this seems like common sense, but we continue to have many patients and staff who complain about this issue.

Thanks for your understanding and cooperation!