HEALTHY CENTER MESSAGE THERAPY AND ACUPUNCTURE

1 Shalimar Drive • Mount Vernon, Ohio
(740) 392-2004 • www.massagetherapymountvernon.com

Confidential Information

Welcome. We want to make your visit as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let us know.

Name:_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Date of Birth:_____ **Age:**_____ ☐ Male ☐ Female

Marital Status:_____ **Occupation:**_____

Home #:_____ **Cell #:**_____ **Text:** ☐ Yes ☐ No

Email:_____

How do you prefer to be contacted regarding appointments or scheduling? Please select one.

☐ Home# ☐ Cell# ☐ Text ☐ Email

Emergency Contact

Name:_____ **Phone#:**_____ **Relation to you:**_____

How did you hear about us?_____

Referred by:_____

What problems or conditions have brought you to us today?

_____

What are your goals for the session?

_____

Are you currently seeing a doctor or chiropractor for any medical conditions? ☐ Yes ☐ No

Please explain:_____

Who is your doctor? _____ **Who is your chiropractor?**_____

Are you taking medication? ☐ Yes ☐ No

Please list the medication:

_____

Continue on next page

Do you have a history of the following? (Check ones that apply)

- ☐ Accident
- ☐ Headaches
- ☐ Fractures
- ☐ Lupus
- ☐ Arthritis
- ☐ Surgery
- ☐ Diabetes
- ☐ Cancer
- ☐ Herpes
- ☐ Fatigue
- ☐ Disk Problems
- ☐ Neck Pain
- ☐ Chronic Pain
- ☐ TMJ
- ☐ Thrombosis
- ☐ Bursitis
- ☐ Depression
- ☐ Stroke
- ☐ Colitis
- ☐ Shingles
- ☐ Sleep Disorder
- ☐ Infectious Disease
- ☐ Whiplash
- ☐ Sprains
- ☐ Tendonitis
- ☐ Seizures
- ☐ Gout
- ☐ Concussion
- ☐ Heart Attack
- ☐ HIV
- ☐ Numbness
- ☐ Wear Contacts
- ☐ Irritable Bowel
- ☐ Abdominal Pain
- ☐ Nervous Tension
- ☐ Fibromyalgia
- ☐ Breast Surgery
- ☐ Allergies
- ☐ Lymphedema
- ☐ High Blood Pressure
- ☐ Difficulty Breathing
- ☐ Tingling
- ☐ Wear Prosthesis
- ☐ Claustrophobia

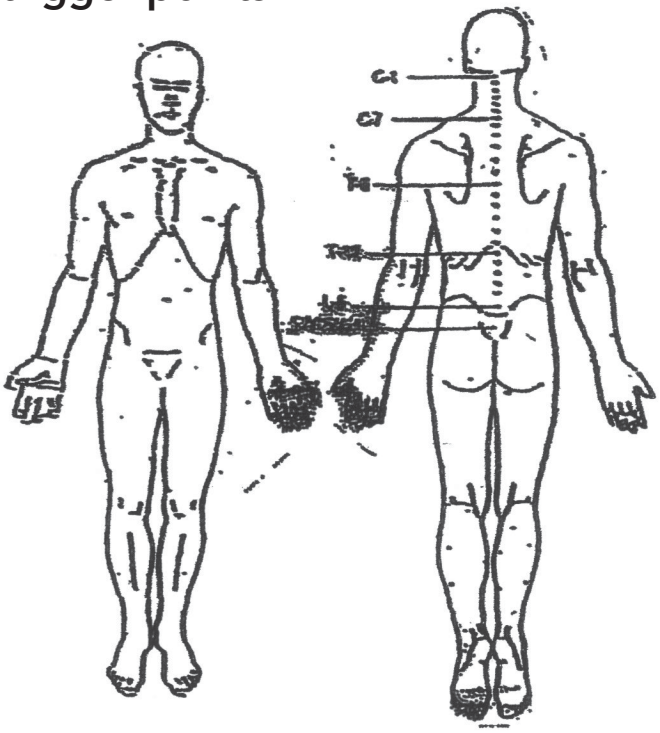
Do you have any of the following today? (Check ones that apply)

- ☐ Sunburn
- ☐ Cold/Flu
- ☐ Headache
- ☐ Poison Ivy
- ☐ Pregnant
- ☐ Fever
- ☐ Open Cuts
- ☐ Bruises
- ☐ Abrasions
- ☐ Inflammation
- ☐ Severe Pain
- ☐ Irritated Skin Rash
- ☐ Lactating
- ☐ Infection

What modalities have you tried in the past? (Check ones that apply)

- ☐ Massage Therapy
- ☐ Trigger Point Therapy
- ☐ Essential Oils
- ☐ Rolfing
- ☐ Shiatsu
- ☐ Chair Massage
- ☐ Personal Training
- ☐ Meditation
- ☐ Reiki
- ☐ Tai Chi
- ☐ Ortho Bionomy
- ☐ Dry Needling
- ☐ Acupuncture
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Heating pad
- ☐ Hot Water
- ☐ Ice or Cold Pack
- ☐ Stretching
- ☐ Counseling
- ☐ Spinal Decompression
- ☐ Reflexology
- ☐ Cranio Sacral Therapy
- ☐ Kinesio-taping
- ☐ Chiropractor
- ☐ Estim/TENS Unit
- ☐ Laser Therapy
- ☐ Cupping
- ☐ Moxa
- ☐ Herbal Supplements
- ☐ External Analgesic Creams
- ☐ Biofeedback
- ☐ Yoga
- ☐ Qi Gong
- ☐ Lymph Drainage
- ☐ Naturopathy

Mark problem areas or trigger points.



PLEASE READ THE FOLLOWING AND SIGN BELOW

- I understand that these sessions are not a replacement for medical care and that no diagnosis will be made.
- It is my choice to receive these therapies. I have reported all the health conditions that I am aware of and will notify my therapist of any changes before each session.
- I am ready to fully participate as a member of the health care team.
- I will try to give 24 hours notice if I need to move or cancel my session.

Date:_____ Signature:_____

Parent or Guardian's Signature for Minors:_____

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Healthy Center Massage Therapy & Acupuncture Office Policies

Welcome to Healthy Center Massage Therapy & Acupuncture. We want you to be comfortable and receive the best care possible. Please do not hesitate to ask any questions you might have regarding your visit, your billing, or our policies.

FEES

The fees charged in this office are comparable to those charged by other healthcare providers in this area with similar qualifications. Please ask to see our fee schedule. We accept personal check, cash, credit cards and health savings account. Please note there is a $35.00 charge for checks returned due to insufficient funds.

Initial_____

INSURANCE COVERAGE

Many insurance companies cover Acupuncture for pain, but we do not claim that yours does. Policies can differ greatly in terms of deductible and percentage of coverage for Acupuncture. We can verify coverage and submit your claim for reimbursement, provided you sign the financial agreement below.

Initial_____

RELEASE OF INFORMATION

Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

Initial_____

CANCELLATIONS

As a courtesy to our office and other patients, we ask that you please notify the office for any missed appointment or cancellation giving more than 24 hours notice for any non-emergency situations.

Initial_____

Financial Agreement/Assignment of Benefits

I, (print full name) _____, am receiving or about to receive health care services in this office. I understand that I am responsible to pay all non-insurance related fees when services are rendered. If I choose to use my insurance I understand I will be responsible for all "non covered" services and/or co-insurance/copays associated with my visit. In addition I authorize insurance payment of medical benefits to Healthy Center Massage Therapy & Acupuncture.

By signing below, I agree to comply with office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Patient Signature:_____ **Date:**_____

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Notice of Privacy Practices for HIPPA

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. **Please review carefully.**

I am required by the **Health Information Portability and Accountability of 1996 (HIPPA)** to provide confidentiality for all medical health records and other individually identifiable information in my possession. This notice is to inform you of the uses and disclosures of confidential information that may be made by Healthy Center Massage Therapy & Acupuncture, and of your individual rights and Healthy Center Massage Therapy & Acupuncture's legal duties with respect to confidential information.

Ways in which I may use and disclose your protected Health information:

I may use and disclose at my discretion your medical records for each of the following purposes only:

- **Treatment:** means providing, coordinating, or managing health care and related services.
- **Payment:** means activities such as obtaining payment for the health care services I provide for you.
- **Health Care Operations:** include the business aspects of running a practice.

I may contact you to provide appointment reminders or change appointments. I will disclose your protected health information to any person you identify that is involved in payment for your care.

I will use and disclose your protected health information when required by federal, state, or local law. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to persons or agencies even if you do not give permission. These situations are as follows:

A. If you threaten grave bodily harm or death to yourself or another person, I am required by law to inform the intended victim and/or appropriate law enforcement agencies.
B. If you report to me your knowledge of physical or sexual abuse of a minor child or an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter.
C. If I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

Any other uses and disclosures will be made only with written authorization. You will be provided with an authorization form upon your request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing. I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate that you understand HIPPA and my operation for use of your health information for treatment, payment, and health care operations as stated above.

Signature:_____ **Date:**_____