Date ___/___/____

Massage Intake Form

Personal Information

Name _____ Phone (day) _____ (evening) _____

Address _____ City/State/Zip _____ DOB _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us? _____

Medical Information

Are you taking any medications? ☐yes ☐no

If yes, please list name and use: _____

_____

_____

Are you currently pregnant? ☐yes ☐no

If yes, how far along? _____

Any high risk factors? _____

Do you suffer from chronic pain? ☐yes ☐no

If yes, please explain _____

What makes it better? _____

_____

What makes it worse? _____

_____

Have you had any orthopedic injuries? ☐yes ☐no

If yes, please list: _____

_____

Please indicate any condition you have had in the past or currently have.

☐Cancer	☐Fibromyalgia
☐Headaches/Migraines	☐Stroke
☐Arthritis	☐Heart Attack
☐Diabetes	☐Kidney Dysfunction
☐Joint Replacement(s)	☐Blood Clots
☐High/Low Blood Pressure	☐Numbness
☐Neuropathy	☐Sprains or Strains

Explain any conditions you have marked above:

_____

_____

Massage Information

Have you had a professional massage before? ☐yes ☐no

What type of massage are you seeking?

☐Relaxation ☐Therapeutic/Deep Tissue

Other _____

What pressure do you prefer?

☐Light ☐Medium ☐Deep

Are you sensitive to any fragrances? ☐yes ☐no

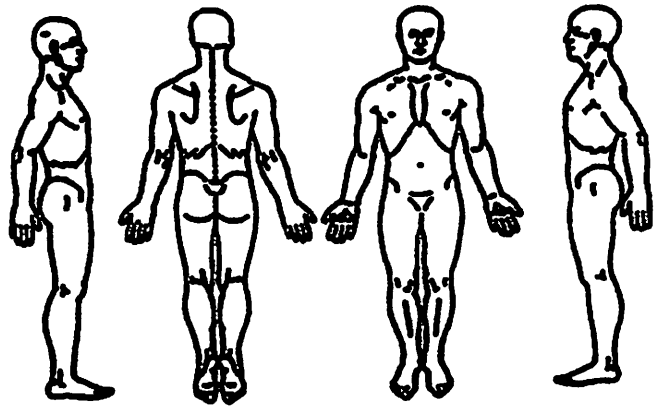
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐yes ☐no

Please explain _____

What are your goals for this treatment session?

_____

Please circle any areas of discomfort



By signing below you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature _____ *Date* _____

ST. PAUL CHIROPRACTIC
& Natural Medicine Center.

Financial Policy

Regarding Insurance Coverage

- **Auto accidents:** In most cases, auto insurance pays 100% for care related to your auto injury. You must notify your insurance company or agent that you are under care at our office, and complete their " Application for Benefits" immediately. If your policy has a deductible, you will be responsible for paying that amount as services are received unless other arrangements are made with our office.

- **Major medical:** Your insurance company may deny payment for the service provided to you for the following reason: **That the particular service received may not be reasonable and necessary under my insurance companies standards.**

For this reason, please read and sign the following statement:

"I have been informed by my physician that he believes that, in my particular case, my insurance may deny payment for the services for the reasons stated. If my insurance denies payment I agree to be personally and fully responsible for payment of said services."

- **Medicare:** Medicare pays a portion of the manipulation charge after the deductible has been met (spinal manipulations only). Medicare does not pay for examinations, x-rays, physiotherapy, nutritional supplements, exercises, consultations, laboratory tests, or orthopedic supports. ***Additional Medicare ABN form must be signed***

- **Worker's compensation:** In most cases, workers compensation insurance pays 100% for care related to your injury. You must notify your employer that you are under care at our office immediately. In general, 12 weeks of care is covered.

Agreement

I have read and understand the above financial policy. I understand that, whether I have insurance coverage or not, I am personally responsible for payment of all charges for services rendered to me. Payment is due the day the service is performed unless other arrangements have been made. I hereby consent to examination, x-rays, and treatment, if needed.

I hereby authorize my attending doctor to release to my insurance company any information concerning my examination or treatment. I understand that St Paul Chiropractic & Natural Medicine Center may have a contract with my insurance company that allows only co-pays to be collected at time of service. By signing this form, I am agreeing to pay any co-pays, deductibles and coinsurance at the time of service. I hereby assign all benefits paid as a result of claims submitted on my behalf to St Paul Chiropractic & Natural Medicine Center. In the event this account is placed with an attorney or collection agency, I am responsible for collection fees, attorney's fees, and court costs

Signature: _____ Date: _____

Witness: _____ Date: _____

464 Hamline Ave South, St Paul MN 55105
Phone: 651-644-7207 Fax: 651-644-6653
www.stpaulnaturalhealth.com

ST. PAUL CHIROPRACTIC
& Natural Medicine Center.

Notice of Privacy Practices Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record to get more information about it by contacting St Paul Chiropractic & Natural Medicine Center.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

You may refuse to sign this acknowledgement

By my signature below I acknowledge receipt of the Notice of Privacy Practices

Patient or legally authorized individual Date Time

Printed name if signed on behalf of patient Relationship

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

This box intended for office staff only

Individual refused to sign:

- ⊗ Communication barriers prohibited obtaining acknowledgement
- ⊗ An emergency situation prevented us from obtaining acknowledgement
- ⊗ Other (Please Specify) _____

Additional Disclosure Authority

⊗ *No other spouse, family member, or friend my have access to my health information.*

In addition to the allowable disclosures described in the "Notice if Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the person indicated below:

Any member of my immediate family: Yes____ No ____

Spouse only: _____ Yes____ No____

Other: (Please Specify)_____ Yes____ No____

Relationship to patient: _____

Name: _____

Signature: _____ **Date:** _____

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INFORMED CONSENT FOR MASSAGE THERAPY

I hereby request and consent to the performance of massage therapy by the therapist/technician named below or other therapists/technicians at St. Paul Chiropractic & Natural Medicine Center. Massage in general provides benefits of stress reduction, relief from muscular tension, spasm, or pain, and it increases circulation and energy flow.

I understand that massage therapists do not diagnose illness or disease, perform any spinal manipulations, nor do they prescribe any medical treatments. I am aware that therapeutic massage is not a substitute for medical examination and I will seek health care for those services.

I accept that massage promises no long-term results nor will it cure my health problems. The therapist must be aware of all health conditions due to certain contraindications or cautions for massage. I have disclosed all such conditions. I will also update any changes to my health in future sessions.

If at any time during the massage the client or therapist/technician is uncomfortable for any reason, they shall immediately say so.

Sexual advances of any kind will not be tolerated.

Children are not permitted in the massage room and must have childcare provided for them during the massage. St. Paul Chiropractic & Natural Medicine Center does not provide childcare services.

Cancellation Policy: A 24-hour notice is required for cancellation of your massage appointment & we reserve the right to charge you the **full cost of your massage appointment**. If you massages services are being covered by an insurance company/3rd party payer you will be held *personally responsible* for the normal cash massage fee associated with your appointment. No call, no shows will not be rescheduled after their 2nd no call, no show.

All information will be kept strictly confidential and will remain with St. Paul Chiropractic & Natural Medicine Center.

I have read and agree with above information. If I have any questions or concerns, I will let the therapist know right away.

Signature: _____ Date: _____

Staff Signature:_____

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