fauntleroychiropractic,P.S.

MASSAGE THERAPY

Name ________________________________ Phone ________________ Alt. Phone _____________

Leave blank if completed online / in-office

Address _____________________________________ City,State,Zip ________________________

Birthdate _____________ Occupation ___________________ Employer _______________________

Email ____________________________________ Referring Physician _______________________

Emergency Contact _______________________ Relationship __________ Phone ________________

How did you hear about us? ____

BACK

FRONT

Circle what you feel:

Sharp
Dull
Stiffness
Aching
Tingling
Numbness
Burning
Constant
Comes and Goes
Other

How often do you feel this? ___________________

Rate pain 1-10 (10 worst) ___________________

When did it first develop? ___________________

What caused it? ____________________________

Is this the first time? ________________________

Is it getting better/worse/same? ______________

What makes it worse? _______________________

What have you done for it? __________________

Other providers seen for it: __________________

Significant related injuries: ____

Circle if you have or had: Cancer Skin allergies Blood clots Heart problems Diabetes

Joint replacements_______________ Neuropathy Fibromyalgia Numbness Sprains/Strains

Other significant health issue ____

Have you received massage before? (Circle) Yes / No (Circle) Treatment / Relaxation

What depth of work do you prefer? (Circle) Light / Medium / Deep / Very Deep

Is there anything you would like the therapist to know, re your condition or preferences?

____

Account information:

- ❑ Medical Insurance – ensure that we have a copy of your valid insurance card, ID, and referral.
- ❑ Work Injury – please present all claim information and paperwork.
- ❑ Auto Accident – please present all claim and attorney information and paperwork.
- ❑ Time of Service/'Cash' – payment at time of service or pre-payment is expected.

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MASSAGE THERAPY – Protocol and Financial Agreement

Name: ____ Date: ______________________

- If you are scheduled outside of chiropractic hours, the front door may be locked for security. You are expected and the door will be opened in time for your appointment.
- In preparation for your massage, please remove contact lenses and all jewelry. Long hair pulled back with clip or band is helpful.
- Massage is generally given while you are unclothed. You may wear undergarments or a swimsuit.
- During your massage you will be draped/covered with a sheet. Only the area being worked on may be exposed.
- Please let the therapist know if you find the pressure too deep or too light. For therapeutic work, 6-8/10 pressure is common.

Please read and check the box on each line below to acknowledge your understanding and acceptance:

❑ I understand that massage is given here for the purpose of relief from muscular tension, spasm or pain, stress reduction, and/or for increasing circulation of energy flow. It is my responsibility to notify my therapist of any changes in my condition prior to treatment.

❑ I understand that the massage practitioner does not diagnose illness or disease. A **diagnosis may be needed** for your claim processing, even if insurance says you don't need a referral.

❑ I understand that if I am using my health insurance, I am responsible to **provide a valid referral** with parameters of treatment: time frame, diagnosis, frequency/number of visits. I understand that a referral does not ensure services will be covered by insurance.

❑ Although Fauntleroy Chiropractic may do an insurance check as a courtesy, actual benefits are not known until processed, and **I accept financial responsibility** for my portion, or for full payment if denied or not covered. I authorize the release of any medical information necessary to process this claim.

❑ I understand that insurance visits past the curative (gets better) treatment parameters may be considered **maintenance or preventive, a non-covered service**. I am financially responsible for visits that are denied/not covered/recovered by audit.

❑ I have been given or offered our HIPAA privacy policy.

❑ I understand that **24-hour notice must be given to cancel an appointment, or a $30 fee applies**.

❑ I will **not get a massage if sick**. It is not appropriate to be in close and extended proximity with the massage provider when likely contagious (cough, sore throat, mucus, etc).

I accept the above agreements, and accept responsibilities stated.

Signature: ____ Date: ____________________

Witness: ____ Date: ____________________

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