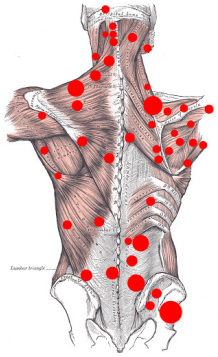
Clinical Massage Therapy

CMT Rocklin
5714 Lonetree Blvd
Rocklin, CA 95765
Office: 916.259.2510
Fax: 916.259.2511
Admin@clinicalmassagerocklin.com



CMT Folsom
2390 E. Bidwell #300
Folsom, CA 95630
Office: 916.260.5843
Fax: 916.260.5847
Admin@clinicalmassagefolsom.com

Confidential Client Information

Name: _____ **Date:**_____

Address: _____ **Phone: ( ) _____-_____**

City: _____ **State:** _____ **Zip:** _____ **Date of Birth:** _____

Email:_____ **Referred by:**_____

Occupation: _____ **Reason for visit:** _____

Is the reason for your visit injury related? ❑Yes ❑No **Date of Injury:**_____/_____/_____

General & Medical Information:

If you answer "yes" to any of the following questions, please explain as clearly as possible.

❑Yes ❑No Have you ever had professional massage?

❑Yes ❑No Are you under the care of a chiropractor?

If yes, what is your Doctors name?

_____

❑Yes ❑No Have you ever seen a physical therapist for this condition?

❑Yes ❑No Are you pregnant?

❑Yes ❑No Are you wearing contact lenses?

❑Yes ❑No Are you diabetic?

❑Yes ❑No Do you have high blood pressure?

❑Yes ❑No Do you suffer from any allergies? If yes, please list:

_____
_____
_____
_____
_____

❑Yes ❑No Have you had any broken bones in the past two years?

❑Yes ❑No Have you ever had surgery? If yes, please explain:

_____
_____
_____
_____
_____

❑Yes ❑No Do you have cardiac or circulatory problems?

❑Yes ❑No Do you suffer from seizure disorders or epilepsy?

❑Yes ❑No Do you experience frequent headaches?

❑Yes ❑No Do you have any other medical condition that I should be aware of?

_____
_____
_____
_____
_____
_____

❑Yes ❑No Are you currently taking medication(s)? If yes, please list medication name and dosage below.

Medications:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Update:____/____/____ Inital:_____ | Update:____/____/____ Inital:_____ | Update:____/____/____ Inital:_____ | Update:____/____/____ Inital:_____

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Please indicate your stress levels: ❑ Low ❑ Medium ❑ High ❑ Extreme

Draw your symptoms on the figures.

1. Identify CURRENT symptomatic areas in your body by marking letters on the figures to the right. Use the letters provided in the key to identify the symptoms you are feeling today.

2. Circle the area around each letter, representing the size and shape of each symptom location.

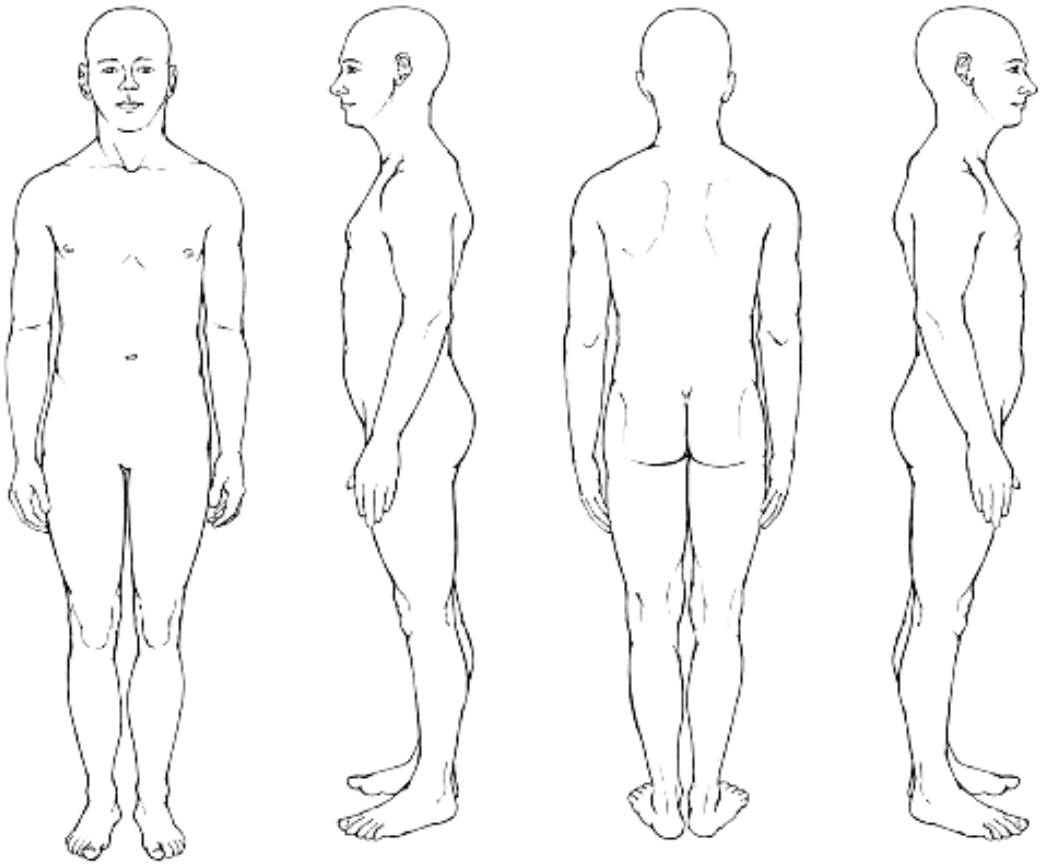
KEY: P = pain or tenderness S = joint or muscle stiffness N = numbness or tingling B= Burning

Identify the intensity of your symptoms.

1. Pain Scale: On a scale of 1 to 10 please indicate the pain level you are experiencing today. _____

Examples: 1 = No Pain 5= Distracting but I can still do things 7= I cannot do certain things due to pain 8= I can't get out of bed due to pain

2. Activities: On a scale of 1 to 10 please indicate limitations you are experiencing in your daily activities. _____



Client Signature: _____ **Date:**_____

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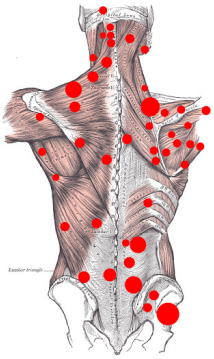

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Client Consent to Use and Disclosure of Health Information

I, _____, understand that Clinical Massage Therapy ("CMT") creates and maintains paper and electronic records describing my personal health history. These records cover:

- Symptoms
- Diagnoses
- Other treatments
- Plans for future treatment

I understand that CMT uses this information to:

- Plan my care and treatment
- Maintain communication with other healthcare providers
- Stand as a record by which a third party (such as an insurance provider) verify services that we've billed for
- Use as a tool to verify that treatments are of quality and practitioners are performing with competence

I, as a client of CMT, understand that I have the right to restrict access to my Protected Health Information ("PHI") and that I may grant permission to disclose my PHI in certain circumstances. Under the HIPAA privacy rule, CMT must obtain patient authorization to use patients' PHI for reasons other than routine treatment, payment, or health care operations including:

- To disclose PHI about a patient to a third party (i.e., an insurance carrier)
- To raise funds for an entity other than CMT
- To disclose records, unless disclosure is required for law enforcement purposes or legal mandates, oversight of the provider who created the notes, use by a coroner or medical examiner, or avoidance of a serious and imminent threat to health or safety

I understand CMT is not required to agree to the restrictions I request. I understand **I may revoke this consent in writing** to prevent any future use of my information from that date forward. I also understand that if I refuse to sign, CMT may refuse to treat me (Section 164.506 Code of Federal Regulations).

I further understand that CMT has the right to change this notice and will send a copy of the revision prior to its effective date to the address I have provided (Section 165.520 Code of Federal Regulations).

I wish to have the following restrictions placed upon my information: _____
_____
_____
_____

I fully understand and ACCEPT / DECLINE the terms of this agreement.

SIGNATURE: _____ DATE: _____/_____/ _____

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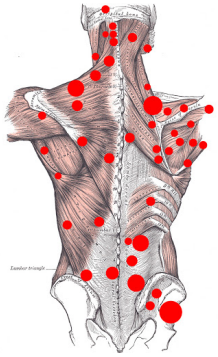

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Billing Policy

The following is a primer to help you, the client, understand CMT's billing process and inform you on what you'll need to do as a client in order for the process to run smoothly. Clinical Massage Therapy is set up to receive direct payments from your insurance provider. For this to work, we need you to:

1. Contact your carrier to determine if they cover massage therapy, and if so under what conditions. (Not all carriers cover massage, and some only in certain settings.)
2. Obtain a current, written prescription for Massage Therapy from your health care provider.

It is important you understand your individual insurance policy in order to set a budget for your healthcare needs. **You are responsible for all charges incurred at Clinical Massage Therapy.** We accept payment in full until your insurance can be verified. If your insurance covers the session you will be refunded any payments made that your insurance covers.

Assignment of Benefits
My signature below authorizes direct payments of medical benefits for services billed to my health care provider:

Int_____

Release of Medical Records
My signature below authorized the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

Int_____

Financial Responsibility
I understand it is my responsibility to pay for all services provided. In the event my insurance company denies payment or makes a partial payment, I agree to be, and remain, responsible for the balance. I also understand and agree, that if Clinical Massage Therapy has contracted with my insurance company at a discounted rate, and the agreed-upon fee has been satisfied, the balance owed on those specific visits will be waived. I have also received and agreed to Clinical Massage Therapy's cancellation policy, and understand that **insurance will not cover the $40 late cancellation fee** and know it will be an out of pocket expense.

Signature:_____ Date:_____

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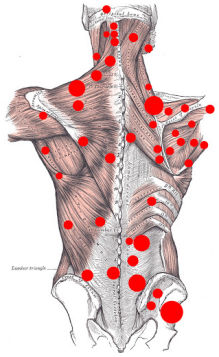

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Cancellation Policy Agreement

You may cancel your appointment without charge with a **24-hour notice** preceding your scheduled Treatment. Same day cancellations will incur a late cancellation fee of **$40**. If you do not call to cancel or do not arrive for your scheduled appointment, you will be charged the full scheduled service price.

Workers Compensation Clients

You may cancel your appointment without charge with a 24-hour notice preceding your scheduled Treatment. If you do not call to cancel or do not arrive for your scheduled appointment an office visit will be deducted from your authorized treatments.

Name:_____ Date:_____

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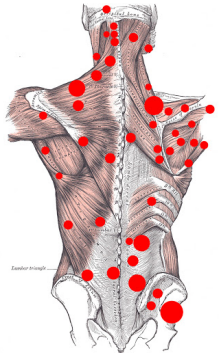

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TEXT MESSAGE ("SMS") NOTICES

Dear Valued Client,

Clinical Massage Therapy offers several different ways to stay in contact with you regarding your appointments. One of those ways is though Text Message ("SMS") reminders the day before your appointment.

The Telephone Consumer Protection Act ("TCPA"), requires us to obtain written consent from our clients wanting to enable the text messaging feature available in our scheduling program.

If you wish to start receiving text reminders, please complete the information below. A copy of this form will be included in your records.

Clinical Massage Therapy would like to thank you for your continued trust and loyalty.

By signing below I am agreeing to receiving automated text message reminders from Clinical Massage Therapy, and understand that standard messaging rates may apply.

PRINTED NAME:_____ PHONE #: _____

SIGNATURE: _____ Date:_____