Natural Choice
CHIROPRACTIC
& massage therapy

MASSAGE CLIENT INFORMATION FORM

Name _____ Birthdate: _____

Address _____

City: _____ State: _____ Zip: _____

Home Phone _____ Work: _____ Cell: _____

Occupation: _____ Job Duties: _____

Primary Care Physician: _____ Phone: _____

Medications Currently Taking: _____

In case of emergency, please contact: _____ Phone: _____

Who can we thank for referring you to our office: ☐ Newspaper ☐ Mail ☐ Sign ☐ Yellow Pages ☐ Referral _____ ☐ Other _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. At *Natural Choice Chiropractic & Massage Therapy,* we are dedicated toward achieving the goal of total lasting health for our members. To better help us achieve this, we need to understand your complete health history. Please help us, help you by taking a few moments to answer the following questions.

PRESENT HEALTH CONDITIONS

Please check all of the following health conditions that you currently have or have had in the past. If you answer yes to any of the conditions below, please provide a detailed description.

Yes	No		
☐	☐	Contact lenses	_____
☐	☐	Dentures	_____
☐	☐	Sensitivity to perfume or dyes	_____
☐	☐	Skin problems	_____
☐	☐	Allergies	_____
☐	☐	Heart problems	_____
☐	☐	Varicose veins	_____
☐	☐	Arthritis	_____
☐	☐	Osteoporosis	_____
☐	☐	Brittle bones	_____
☐	☐	Spinal problems	_____
☐	☐	Contagious health conditions	_____
☐	☐	Regular participation in sports or fitness activities	_____
☐	☐	Other health problems or concerns	_____
☐	☐	Have you ever had a professional massage before? If yes, where and type?	_____
☐	☐	**Are you, or do you think you may be pregnant?**	_____

My goal for the massage session today is:

- ☐ To relax
- ☐ To get work on my specific areas of soreness / tension
- ☐ To help relieve my current health concern / problem
- ☐ To experience my first therapeutic massage
- ☐ Other: _____

I would like to get a massage:

- ☐ When I feel I need it
- ☐ Occasionally
- ☐ Regularly
- ☐ I would like more info on membership pricing & referral incentives

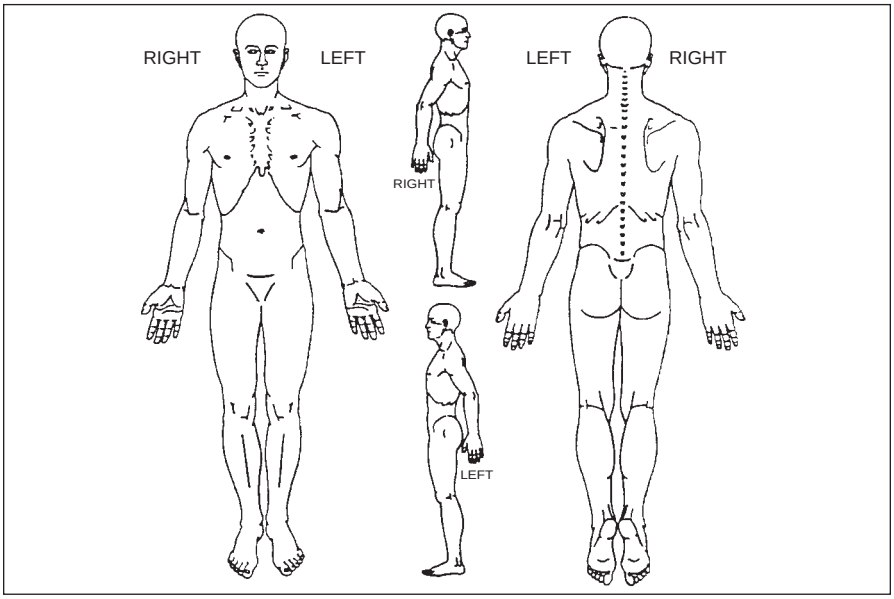
I feel the pressure that would best fit my needs would be:

☐ Very light / light ☐ Medium ☐ Deep / Heavy ☐ I don't know

☐ Other: _____

* The therapist will always work within your tolerance level. It is your responsibility to tell him/her if the pressure is/isn't correct for you.

PRESENT HEALTH CONDITIONS - *Continued*



Please indicate any area of tension or soreness that you would like the massage therapist to address specifically.

Please circle or "X" the area to the left.

Prioritize ONLY specific problem areas:

_____Neck _____Upper back _____Hip

_____Legs _____Lower back _____Arms

_____Hands _____Upper Chest _____Feet

_____Face / Scalp

(1 - High Priority, 2 - Secondary, 3 - If we have time)

CONSENT FOR TREATMENT, HEALTHCARE OPERATIONS, AND PAYMENT

Purpose of Massage Therapy

I understand that the massage therapy given at this clinic is for the purpose of stress reduction, relief of muscular tension or spasm, or for increasing energy flow. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. I understand that massage therapy is not a substitute for medical treatments and/or diagnosis and that it is recommended that I see a physician for any physical ailments that I may have. I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

To Our Clients with Insurance

In order for us to bill your insurance company for massage, you MUST be a chiropractic client. Please remember that your insurance coverage is a contract between you and your insurance company and is not a substitute for payment. We are happy to work with you and your insurance company but you are ultimately responsible for your account. We will gladly bill your insurance company, but your portion is due at the time of each visit. After receiving payment from your insurance company, you will then receive a bill from our office if there is any remaining balance. Unless arrangements are made with our office, payment is required within 15 days of notification, regardless of deductible and other co-insurance.

To Our Patients without Insurance

We request that all charges be paid at the time of each visit, unless financial arrangements are made with our office prior to services.

Non-Payment Policy

If your balance is over 30 days past due, the following charges will apply:

- A re-billing fee of $5.00
- If your account becomes delinquent, you will be financially responsible for any action we must take to collect the delinquent amount due. These fees may include mailing costs, staff time, court costs, and attorney fees.

Missed Appointment Fee for Massage

If you cannot keep your massage appointment, please provide at least 24 hours notice or **you will be charged a $30 missed appointment / cancellation fee.** Your insurance will not pay for this fee and you will be responsible for full payment for missed massage appointments.

Notice of Privacy Practices

I acknowledge that Natural Choice Chiropractic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices is also provided upon request at the main administration desk of this practice. I understand I have a right to review Natural Choice Chiropractic's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Natural Choice Chiropractic. This Notice also describes my patient rights and Natural Choice Chiropractic's duties with respect to my protected health information.

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Natural Choice Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Chiropractic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Natural Choice Chiropractic insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

Printed Name: _____ Witness: _____