Eagle River Therapeutic Massage

Confidential Medical Massage Intake

ERTM

Personal Data

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ Zip: _____

Phone #: Hm. _____ - _____ - _____ Wk: _____ - _____ - _____ Mobile: _____ -_____ - _____ Sex: ____ M ____ F

Birthday: _____ Emergency Contact: _____ Ph. _____ - _____ - _____

Email: (Required) _____ (We provide appointment confirmations via email)

Occupation / Activities: _____

How did you hear about us? (Circle) Internet / Cache / Client or Patient / Other: _____

Referred Condition Information

Referring Physician: _____ Phone: _____

Diagnosis: _____ Date Problems began: _____

Describe current Condition: _____

How did the condition begin? _____

What makes the condition worse? _____

What makes the condition better? _____

What range of motion / physical activities can you no longer perform because of the condition? _____

_____

What other treatments have you received for this condition? _____

_____

Specific Symptom(s) Description

How severe is your pain? (Circle) ___ Severe ___ Moderate ___ Light

How often are your symptoms present? ___ Constantly ___ Frequently ___ Occasionally ___ Intermittently

Describe your current symptoms / pain? ___ Shooting ___ Throbbing ___ Dull/Achy ___ Sharp/Stabbing

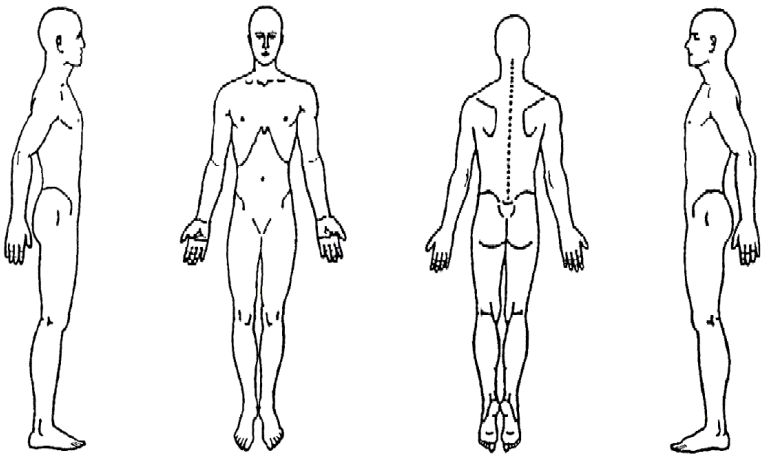
___ Tingling ___ Numbness ___ Burning ___ Soreness

How is the quality of your sleep? _____

What goals do you hope to achieve with therapeutic massage? _____

Symptom(s) Location

Draw an X where you feel symptoms described above.



General Health History

Circle current conditions. Check past conditions.

Neck / Spine	Varicose Veins	Cold / Flu / Fever
Back Pain or Injury	High Blood Pressure	Pregnancy
Sciatic / Leg / Hip Pain	Low Blood Pressure	Liver / Kidney Ailment
Wrist / Arm / Shoulder Pain	Skin Disorders	Heart / Circulatory Problems
Jaw Pain	Infectious Disease	Fibromyalgia / CFS
Sports Injuries	Diabetes	Cancer
Headache	Arthritis	Other _____

Other Accident, Injury, Surgery, Medication & Miscellaneous Information

Accident or Injury: _____

Surgery or Misc.: _____

Currently receiving medical or chiropractic care? ___ Yes ___ No.

If yes, explain: _____

Are you currently taking medications (prescription or over-the-counter)? ___ Yes ___ No.

If yes, explain: _____

Do you have any allergies? If yes, explain: _____

Massage Information

Have you ever received professional massage? __ Yes __ No. Frequency? _____ Date of Last Massage: _____

What types of massage have you had before? _____

What type of pressure are you comfortable with? _____

Lifestyle Factors

Do you experience excessive stress? _____

List any exercise activities and frequency: _____

List any work or home activities that may affect you physical or emotional well being (heavy lifting, standing or sitting for long periods, computer work …): _____

_____

Miscellaneous

Do you have any other concerns or information not addressed above? _____

_____

Acknowledgments

The above information is accurate and true to the best of my knowledge. I will update the treating massage practitioner of any changes to the above information or changes in my health status.

I acknowledge that the medical massage treatment provided is for the prescribed or referred condition(s) diagnosed by your licensed medical professional (doctor, chiropractor, naturopath, etc.). It is my choice to receive medical massage treatment. I understand that there is no guarantee of specific progress or improvement to my condition from medical massage.

I understand that massage practitioners do not diagnose illness, disease, or any other physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations.

I agree to communicate with my practitioner any time I have any concerns about my treatment and progress.

I authorize my massage therapist to release / obtain information to / from my other health care providers regarding my treatment.

Client or Guardian Signature: _____ Date: _____

Medical Massage Policies and Rates

Service Policies

You must provide a written prescription or referral for massage therapy from a licensed medical health provider (Physician, Chiropractor, Naturopath, etc.) to receive medical massage treatments. It must include appropriate diagnosis code(s). We prefer the prescribing or referring health care provider to include treatment frequency, duration, treatment goals and reporting instructions.

We provide medical massage treatments only to the prescribed area(s) or diagnosed condition(s) diagnosed by your licensed health care provider. If you request massage unrelated to your prescription, you will be charged separately for those massage services provided. You will be responsible for full payment of those massage charges at the time of service.

Medical Massage requires the application of advanced knowledge and skills, continued communication with you, the referring / prescribing health care provider, your insurance company, and maybe your attorney etc. Frequently lengthy payment delays incur resulting from the insurance and legal settlement processes.

These additional requirements necessitate different fee schedules for our Medical Massage (medical care) and our Wellness Massage (personal care).

Medical Massage Fees

97124 Massage Therapy $24 per 15 minutes – 1 unit of treatment (New fees start Sept 1st, 2011 $28 per unit of treatment)

97140 Manual Massage $24 per 15 minutes – 1 unit of treatment (New fees start Sept 1st, 2011 $28 per unit of treatment)

It is your responsibility to check with your insurance plan to determine the amount of coverage your plan provides. Be prepared to provide any co-payments that your insurance plan requires at the time of service.

Payment Policy

Eagle River Therapeutic Massage (or our billing service) will bill your insurance company directly under the following conditions:

Medical Health Care Plan Coverage: Verbal verification of coverage

Workers Compensation Claims: verbal verification of coverage

Auto Accident Claims:

PIP: Verbal verification

Second Party Coverage: Written verification of coverage

Third Party Coverage: Signed 3rd party Coverage policy and letter of guarantee signed by patients attorney.

All insurance account balances are due 90 days from the date of service, and any outstanding balances incur a 1% per month compound interest charge unless a payment plan is agreed upon..

We offer a no interest payment plan for patients without insurance coverage or denied claims. You will be required to sign an agreed upon contract, specifying $ amount, frequency and duration of payments. Late payments will incur a 1% per occurrence compound interest charge.

Past due accounts over 90 days may be subject to a $15 re-billing fee. We will initiate collection procedures if no payment is made on your account for 120 days. You will be responsible for payment of reasonable attorney fees, collection agency fees, and any court costs incurred to collect on your account.

It is your responsibility to notify us if you are experiencing financial difficulties prior to incurring any late fees or interest charges. We will do our best to provide a reasonable payment plan.

Cancellation Policy

Please call or email us 24 hours in advance of the scheduled appointment time if you need to cancel.

Appointments cancelled with less than 2 hours prior to the scheduled appointment time will be subject to a charge of $15 and missed appointments will be charged $25 of the massage service booked.

Even if the appointment was a Medical Massage appointment, you will be personally responsible for payment (your insurance will not pay for late cancellation or missed appointment charges).

Patient Agreement

I have read and fully understand the eagle River Therapeutic Massage policies and fees stated above and agree to abide by them.

Patient or Guardian Signature _____ **Date** _____