Palmer Chiropractic Clinic

24837 – 104th Ave. SE, Ste 100 – Kent, WA 98030,(253) 854-7700

X-Ray #:

File #:

MASSAGE CONFIDENTIAL PATIENT INFORMATION

If your symptoms/complaints are due to an on-the-job injury or an automobile accident please tell the receptionist before filling out this form.

Name ______________________ Today's Date __________

Home phone ______________ Work Phone ______________

Address ______________ City __________ State _____ Zip _______

Age ________ Birthdate ________ Sex ______ Status M S W D # of Children ______

Height ___'___" Weight ______lbs. Social Security # __________ Driver lic. # __________

Occupation __________ Employer __________ Years Employed ______

Employer's Address __________ City __________ State _____ Zip ______

Emergency Contact ______________ Phone __________

Person Responsible for billing ______________ Relationship to you __________

(Fill out these two lines if not you) Home phone ________ Work Phone ________ Birthdate ________ SSN: ________

Address ______________ City __________ State ___ Zip _____

Insurance Information: ☐ Labor & Industries; ☐ Auto Insurance; ☐ Personal Medical; ☐ Case/Other

Health Insurance Co. ______________ Phone __________

Address ______________ City __________ State _____ Zip _____

Policy # __________ Group # __________ ID # __________

Referred By: ______________ Primary Care Physician: ______________

Please answer the following questions by checking the appropriate box and providing any necessary clarifications.

YES	NO	
☐	☐	Have you ever has a professional massage? What other ways do you relieve stress? __________
☐	☐	Do you exercise regularly or partake in any sports? If yes, what kind and how often? __________
☐	☐	Are you currently under the care of a physician or other health care provider for a specific condition? If yes please describe. __________
☐	☐	Do you take any medication (including aspirin or ibuprofen)? If yes, please list medication, dosage, and for what condition. __________
☐	☐	Do you have skin problems or allergies? If yes, please describe. __________
☐	☐	Have you every had surgery? If yes please describe. __________
☐	☐	Do you have or have you ever had cancer? If yes, please describe. __________
☐	☐	Do you have or have you ever had heart problems? If yes, please describe. __________
☐	☐	Do you have high or low blood pressure? If yes circle one.
☐	☐	Do you have varicose veins, blood clots, or any other circulatory disorder? If yes, please describe. __________
☐	☐	Do you have diabetes? If yes, how is it controlled and what type of diabetes. __________

☐ ☐ Do you have arthritis? If yes, circle what type: Osteoarthritis, Rheumatoid or Psoriatic Arthritis. Where is it located? ______________________

☐ ☐ Do you have spinal problems? If yes, please describe. ______________________

☐ ☐ Do you experience prolonged episodes of depression or other emotions? ______________________

☐ ☐ Are you pregnant? If yes, what stage? ______________________

☐ ☐ Do you wear contacts? Are they hard or soft? (circle one)

☐ ☐ Do you wear dentures?

☐ ☐ Do you wear hearing aids?

☐ ☐ Do you have any needs that require special attention? If yes, please specify. ______________________

☐ ☐ Do you have any other medical conditions that the massage therapist should be aware of before you receive a massage? If yes, please describe. ______________________

☐ ☐ Do you want specific results from your massage? If yes, please describe. ______________________

Name Symptoms or Problem Areas (for example – headache, tension, pain). Then rate the intensity on a 1 to 10 pain scale with 10 being the worst possible pain. Also note how long each symptom has been present.

____

PAIN CHART

Please circle your area of complaint and add the number on the drawing that most closely describes the sensations you feel.
Use arrows to show radiating pain or odd sensations.
Fill this out very accurately.

1. Pain
2. Tightness/stiffness/tension
3. Swelling
4. Scars
5. Spasms
6. Throbbing
7. Stabbing
8. Pins & Needles
9. other ____________

Place an **X** along the line in the following boxes to demonstrate you pain intensity.

Neck-Shoulder-Arm Pain	Mid Back Pain	Low Back and Leg Pain
On a scale of zero to ten, I rate my discomfort as follows	On a scale of zero to ten, I rate my discomfort as follows	On a scale of zero to ten, I rate my discomfort as follows
(————————)	(————————)	(————————)
0 no pain — 10 severe pain	0 no pain — 10 severe pain	0 no pain — 10 severe pain

INSURANCE CLIENTS / PATIENTS

It must be fully understood that the health insurance contract is between you and your insurance carrier and you are fully responsible for any service not paid by your insurance. I also understand that I am financially responsible for non-covered services. I authorize the Massage therapist to release any information required.

Clinic policy regarding insurance assignment:

1. Since by taking your insurance on assignment, we have to wait for payment, this courtesy may be withdrawn if circumstances warrant it.
2. Your insurance should pay within 30 days. If your insurance has not paid within 60 days, you may be asked to pay the balance due and be reimbursed by your insurance company. Any unpaid balances will be charged 1.5 percent interest monthly.
3. We will bill your insurance one or more times per month as long as you are receiving care in this clinic.
4. You must pay your co-pay amount per your insurance carrier (HMO, PPO, IPA) the day of each treatment.
5. Our clinic does NOT guarantee that your insurance will pay. We will make an attempt at the beginning of your health care to receive verification of your policy and what it covers although, in the end, verifying your benefits is your responsibility. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. Exceptions for this are the individual contracting from your doctor with the managed care organizations, which they are contracted to.
6. Our clinic will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. Our clinic will make every attempt to verify your insurance coverage with your insurance company but we cannot be held accountable for misinformation given to us by your insurance company. Always rely on your insurance plan documentation.
8. It is your responsibility to keep track of any necessary referrals or numbers of treatment visits allowed by your insurance plan.

Please be advised that there is a $35.00 Service Charge on all returned checks.

ALL CLIENTS / PATIENTS

Unless other arrangements have been made, **PAYMENT IS EXPECTED AT THE TIME OF SERVICE**
Charges Must Be Paid In Full. We offer many payment plans to help make care affordable.

If you must miss a scheduled appointment at this clinic you are required to give 24 hours notice. If 24 hours notice is not received, the client/patient may be subject to a cancellation fee of $75.00 for which the insurance company is not responsible.

MASSAGE CONSENT

I hereby request and consent to the performance of massage therapy and other massage procedures, including various modes of physio-therapy such as heat and/or ice, on myself (or on the client/patient named below, for whom I am legally responsible) by one of the massage therapists at Palmer Chiropractic Clinic – Kent, Inc. PS who now or in the future may massage me.

As with any form of treatment I understand that, although very small, there may be risks to my health. I also acknowledge that no guarantee has been made nor has any assurance of results been given to me by any massage therapist or provider of clinical service in this clinic regarding the procedures I've consented to.

I further understand that massage practitioners do not diagnose illness, disease, or other physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that I see a physician for any physical ailment that I might have. I have stated all my known medical conditions and take it upon myself to keep the massage practitioner updated on my physical health.

I clearly understand and agree that I am responsible for all charges for services rendered to me and I am personally responsible for payment.

I have read and agree with all the above policies.

Date: ______________________ **Signature:** ______________________________________

CONSENT TO TREAT A MINOR

I hereby authorize the Palmer Chiropractic Clinic – Kent Massage Therapists and whomever they may designate to administer massage therapy as deemed necessary. I also hereby authorize the above Massage therapist to administer Massage therapy if a parent or guardian is unable to be in attendance at time of clinic visit or visits and I understand that I am fully responsible for any and all unpaid balances.

Name of child ____

SIGNED ____ DATE ____________________
(Parent or Guardian)

To all massage patients:

If you must miss a scheduled massage appointment at this clinic you are required to give 24 hours notice. If 24 hours notice is not received, the patient is subject to a cancellation fee of $75 which the insurance company is not responsible for. If you leave a credit card on file with us, the $75 will be lowered to $40.

◯ I DO NOT wish to keep a credit card on file but understand and agree to the terms above.

◯ I wish to keep a card on file and understand and agree to the terms above.

Card Number______________________________________

Name on Card______________________________________

Exp Date___________ CVV ___________Zip Code_________

Signature ___________________________________ Date_____________

Witness_____________________________________Date______________

☐ ☐ Do you have arthritis? If yes, circle what type: Osteoarthritis, Rheumatoid or Psoriatic Arthritis. Where is it located? ______

☐ ☐ Do you have spinal problems? If yes, please describe. ______

☐ ☐ Do you experience prolonged episodes of depression or other emotions? ______

☐ ☐ Are you pregnant? If yes, what stage? ______

☐ ☐ Do you wear contacts? Are they hard or soft? (circle one)

☐ ☐ Do you wear dentures?

☐ ☐ Do you wear hearing aids?

☐ ☐ Do you have any needs that require special attention? If yes, please specify. ______

☐ ☐ Do you have any other medical conditions that the massage therapist should be aware of before you receive a massage? If yes, please describe. ______

☐ ☐ Do you want specific results from your massage? If yes, please describe. ______

Name Symptoms or Problem Areas (for example – headache, tension, pain). Then rate the intensity on a 1 to 10 pain scale with 10 being the worst possible pain. Also note how long each symptom has been present.

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PAIN CHART

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3. We will bill your insurance one or more times per month as long as you are receiving care in this clinic.
4. You must pay your co-pay amount per your insurance carrier (HMO, PPO, IPA) the day of each treatment.
5. Our clinic does NOT guarantee that your insurance will pay. We will make an attempt at the beginning of your health care to receive verification of your policy and what it covers although, in the end, verifying your benefits is your responsibility. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. Exceptions for this are the individual contracting from your doctor with the managed care organizations, which they are contracted to.
6. Our clinic will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. Our clinic will make every attempt to verify your insurance coverage with your insurance company but we cannot be held accountable for misinformation given to us by your insurance company. Always rely on your insurance plan documentation.
8. It is your responsibility to keep track of any necessary referrals or numbers of treatment visits allowed by your insurance plan.

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Signature ___________________________________ Date_____________

Witness_____________________________________Date_____________