CLIENT REGISTRATION & HEALTH INFORMATION

Name_____ Date: _____

Address _____City_____ Zip_____

Phone:_____Cell_____DOB_____

Occupation: _____

Emergency contact_____Phone_____

*How did you hear about us? _____ Referred by_____

E-mail (optional) _____

Have you had Massage or Bodywork before? Yes No

☐ Hospitalizations	☐Cancer/tumors	☐ Neck pain	☐Shoulder pain
☐ Surgeries/Accidents	☐HIV positive	☐infectious disease	☐Back Pain
☐ High-Low Blood pressure	☐Diabetes	☐Allergies	☐Low Back pain
☐Heart attack	☐Scoliosis	☐Rashes	☐Headache/migraine
☐Stroke/ blood clots	☐Herniated disk	☐Warts	☐Broken bones
☐ Breathing difficulties	☐Bursitis	☐Fatigue	☐Numbness/tingling
☐ Varicose veins	☐Arthritis	☐Currently pregnant	☐ Athletes foot

Other/Explain:

_____

Current medications_____

I understand that massage and Bodywork sessions are for the purpose of relaxation, stress reduction and relief from pain or muscle spasms. I further understand bruising or flu like symptoms may occur as result of massage. I have provided all my known medical information. I acknowledge that manual therapy is not a substitute for medical diagnosis and treatment and is recommended that I contact a licensed health care provider for any medical conditions or concerns that I might have.

Signature Date Parent/guardian (if under 18) Date

24 HOUR CANCELLATION POLICY

Scheduled services are the core of our business. Because appointments are reserved especially for you we require that you notify us 24 hours in advance to change or cancel your appointment without penalty. If you are late your appointment will be shortened to accommodate other scheduled appointments.

YOU WILL BE CHARGED THE FULL COST OF YOUR APPOINTMENT IF YOU DO NOT GIVE US 24 HOURS NOTCE OF CHANGING/CANCELLING YOUR APPOINTMENT.

Signature Date Parent/guardian (if under 18) Date

HIPPA CONSENT TO THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION FOR THE TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS OF ORGANIC WELLNESS

I understand that as part of my health care, Organic Wellness originates and maintains paper and electronic records describing my health history, symptoms, examinations and test results, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying treatment to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality.

I understand and have been provided with Notice of Privacy Practices (Revision Dated April 14, 2003) that provides a more complete description of how medical information about me may be used and disclosed. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for specific purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I wish to have the following restrictions to the use of disclosure of my health information:

_____

_____

I understand that I may revoke this agreement in writing, except to the extent that the organization has already taken actions thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I understand that as part of this organizations treatment, payment or health care operations, it may become necessary to disclose my PHI to another entity, and I consent to such disclosure for these permitted uses, including disclosure electronically via fax or computer

I fully understand and accept the terms of this consent

Client Signature_____ Date: _____

Reason for Refusal to sign: _____

Massage Therapists Signature: _____

FINANCIAL AGREEMENT

Please read this agreement carefully.
We will be happy to answer any questions you may have.

I, _____ (patient), understand that my insurance is an agreement between the insurance company and myself.

I understand that ORGANIC WELLNESS will assist me in billing my insurance carrier. However, I am fully responsible for any payments due that are denied by my insurance company.

I assign payments to be made on my behalf to this provider for any services furnished to me. I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the sixty-first (61st) day.

In the event my insurance company does not pay in full for services provided, I understand that I will be receiving a bill for the services provided.

In the event fees are not paid as requested, a collection agency and possibly legal action may follow. If so, I _____ (patient), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

Signature: _____ Date: _____

INSURANCE INFORMATION

MVA PIP (We do not do 3rd party billing) _____ ☐

Insurance Company: _____ Adjuster Name: _____

Billing Address: _____

Phone: _____ Fax: _____

Claim #: _____ DOI: _____

Workers Compensation _____ ☐

Have you received massage/bodywork for this claim before? Yes ☐NO: ☐ Claim # _____

Sessions _____ Date claim opened _____

Billing Address: _____

Phone: _____ Fax: _____

Private Health Primary _____ ☐

Subscriber Name_____D.O.B: _____

Subscriber #: _____ Group#: _____

Insurance Company: _____ Massage Covered Yes ☐NO: ☐ At %_____

Preauthorization Required? Yes ☐NO: ☐ RX Required? Yes ☐NO: ☐ Send to: _____

Subject to deductible? Yes ☐NO ☐ Deductible Amt: _____ Has it been met? Yes ☐NO: ☐

AMT Met $ _____Coinsurance %: _____ Copay $ _____

Private Health Secondary _____ ☐

Subscriber Name_____D.O.B: _____

Subscriber #: _____ Group# _____

Insurance Company: _____ Massage Covered Yes ☐NO: ☐ At %_____

Preauthorization Required? Yes ☐NO: ☐ RX Required? Yes ☐NO: ☐ Send to: _____

Subject to deductible? Yes ☐NO ☐ Deductible Amt: _____ Has it been met? Yes ☐NO: ☐

AMT Met $ _____Coinsurance %: _____ Copay $ _____