Body In Motion
Massage Therapy, LLC

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Vancouver, WA 98663

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Date: _____

Name (Last, First, M.I.) _____ DOB _____

Email Address _____ Add to Mailing List? Y N

Address _____ City, State, Zip _____

Home Phone _____ Cell _____ Work _____

Occupation _____ Employer _____

Emergency Contact _____ Relationship _____ Phone _____

INSURANCE INFORMATION I bill many insurance carriers. If you have been in an auto accident or have suffered an on-the-job injury, you must let me know. I am able to bill your personal health insurance, auto and workers comp insurance. Please provide insurance card with ID.

Responsible Party (if different from above)

Name (Last, First, M.I.) _____ DOB _____

Address _____ City, State, Zip _____

Home Phone _____ Cell _____ Relationship _____

Employer _____ Address _____

Primary Insurance Company _____ **ID#** _____

Claim # _____ Adjuster Name / Contact Person _____

Address _____ City, State, Zip _____

Phone _____

Secondary Insurance Company _____ **ID #** _____

Claim # _____ Adjuster Name / Contact Person _____

Address _____ City, State, Zip _____

Phone _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondence, billing statements and any other information to my attorneys, health care providers and insurance company case manager. **I understand that I am responsible for all charges for all services provided by Body in Motion Massage Therapy, LLC. In the event the insurance company denies benefits for any reason or make partial payments, *I understand that I am responsible for any balance due payable upon notice of denial.***

_____ _____

Patient Signature Date

Consent to treat a minor: By my signature below, I hereby authorize Body in Motion Massage, LLC to administer massage/therapeutic massage techniques to my child or dependent as they deem necessary.

_____ _____

Signature of Parent / Guardian Date

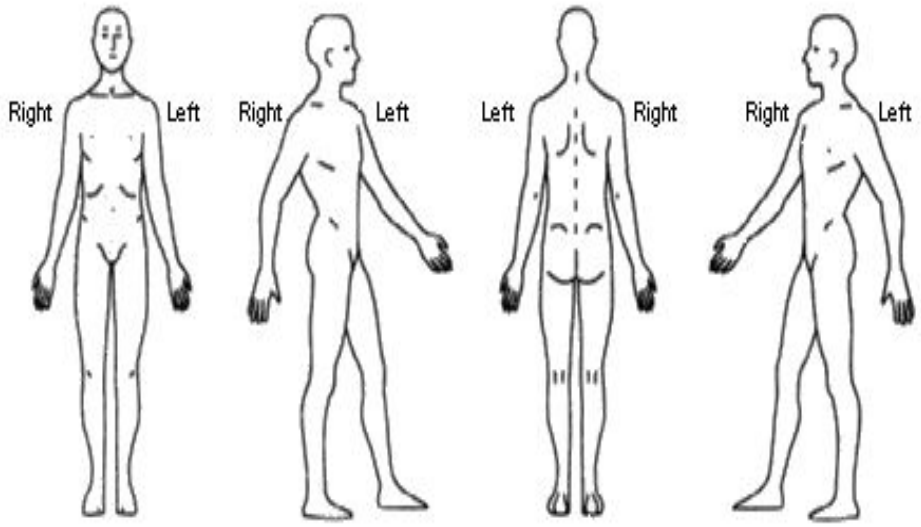
MEDICAL INFORMATION (If you need more room, please use the back side of the paper. All information provided is confidential.)

Primary Care Provider _____ Phone _____
Address _____ City, State, Zip _____

Referring Physician _____ Phone _____
Address _____ City, State, Zip _____

What are your health concerns today?_____
_____

Date of injury/Pain started? _____
Was the injury the result of: Car accident? **Y N** Work Related Injury? **Y N** Other? **Y N**
What is your pain / tension level, if any? **Least 0 1 2 3 4 5 6 7 8 9 10 Greatest**
Is there anything that makes your condition worse? Explain _____
Are you currently under Physician, Chiropractic, PT care for your injuries/pain? **Y N**
What diagnostic tests have you had? (MRI, X-ray, CT scan, etc…) _____
Any prior surgeries/Injections_____ Date _____
List any current prescription / non-prescription medications or supplements you are taking _____
_____
Have you ever had a massage before? **Y N** What type? Relaxation Deep Tissue Medical / Sports Massage Energy Work
Do you have any allergies to lotions or oils? **Y N**
What forms of exercise or sports do you participate in? _____
Ladies are you pregnant? **Y N** If so, do you have a referral from your doctor to receive massage? Y N
Please mark areas of pain or complain on the figure below P = Pain T = Tightness N = Numbing / Tingling



I understand that massage / therapeutic treatment I receive is provided for the basic relaxation / relief of muscular tension. If I experience pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examinations. I am aware of the risks of massage and treatment work and give my consent. I also understand that any illicit or sexual suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I will consult my practitioner immediately with any questions or concerns that I may have and have stated all medical conditions that I am aware of and will keep my practitioner informed of any change.

_____ _____
Patient Signature Date

PAYMENT POLICY AND PATIENT AGREEMENT

Body in Motion Massage Therapy Payment Policy: Payment due at time of service. Exceptions below:

Private Insurance: The client is required to pay any co-payment / deductible at time of treatment. If your insurance company does not pay within sixty (60) days from the treatment, you the client are required to make payment to me directly.

Insured Accidents: I will require your Insurance Company information or other party's insurance information along with a Claim Number and Claim Adjuster's Name to bill your personal injury protection. If medical expenses exceed policy limits, your private insurance will be billed.

Uninsured Accidents: Pending settlement of your claim, I may agree to wait for payment of services rendered in your care. However, I do require some payment (service fee less the professional component) at the time of service. Remember, you are still responsible for payment, whether or not you collect from an at-fault party. ***If I agree to wait for payment, you and your attorney must sign an assignment of insurance benefits to me.***

Work Injuries: If you were injured on the job in Washington State, and are covered by appropriate workers' insurance, I will file a claim and bill your workers' insurance. Workers with accepted claims in Washington State are not liable for costs of care.

Late Fees: Unpaid bills for your treatment older than ninety (90) days will accumulate interest at the rate of 12% annually (1% monthly) until paid in full. If I hire an attorney or collection agency to collect past-due bills, you will be liable for any attorney, court and collections costs.

Authorization to Release Information: I have read the Body in Motion Massage Payment Policy and Patient Agreement and agree to the stated terms. By signing below, I authorize Body in Motion Massage Therapy to release information about my physical condition (or that of my child / minor) to any insurance company or my attorney in order to process my bill for payment.

YOUR PRIVACY | HIPAA
Notice of Privacy Practices **Effective: April 14, 2003**

Body in Motion Massage Therapy is dedicated to preserving your "Protected Health Information " (PHI). I am required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This notice of Privacy Practices describes your rights and my duties with respect to you and your private health information.

Body in Motion Massage Therapy may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations.

I may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

Your PHI means health information, including your demographic information collected by me, or other healthcare providers, a healthcare clearing house, or an employer. This protected health information relates to your past, present or future physical or mental health or condition, and identifies you, or there is a reasonable basis to believe the information may identify you.

You are provided the right to inspect and receive a copy of your medical information that I maintain, amend or correct that information, obtain and account disclosures of your medical information, request that I communicate with you confidentially, request that I restrict certain uses and disclosures of your health information and file a complaint if you think your rights have been violated. ***All requests and complaints must be made in writing.***

I have available a detailed Notice of Privacy Practices (long form) which fully explains your rights and my obligations under the law. You have the right to receive a copy of my most current Notice in effect. Please ask me and I will provide you with a copy.

I have the right to revise my Notice. The effective date noted above indicates the date of the most current Notice in effect. If you have any questions, concerns or complaints about the Notice of your medical information, please feel free to contact me directly.

I have read and received a copy of the Notice of Privacy Practices, Payment Policy and Patient Agreement.

_____ _____

Patient Signature Date