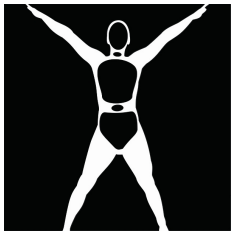
TREATMENT MASSAGE INTAKE FORM



Name:	Email:
Street Address:	Phone (h):
City/State/Zip:	Phone (w):
Birthday:	Phone (c):
	Emergency Contact:
	Emergency Phone:

While you proceed through this intake form, please answer each question honestly. Also, please take the time to elaborate on your answers. The more information you give me, the better I will understand your health situation. Thank you.

MEDICAL HISTORY

Do you have/wear:
Contact Lenses? Y / N
Dentures? Y / N
Difficulty Hearing? Y / N
Hearing Aids? Y / N
Other Prosthetic or Difficulty? Y / N

Please list any medications (prescription or non-prescription) that you are taking, or have taken in the past two weeks. Please include the name, dosage, most recent time of taking the medication, and the purpose of the medication (if known). (If you need more space than what is provided, please ask for an additional sheet of paper).

Name of medication	Dosage	Most recently taken on…	Purpose of medication

Do you have any allergies, especially skin allergies (to products found in lotions, etc.)?

Do you currently have any broken skin, such as heavy acne, cuts, sores, rash, etc.? Please include onset and location.

Please describe any injuries, surgeries, or medical condition you have had, or currently have. Please include date of onset, course of treatment, and current status of the condition. (If you need more space than what is provided, please ask for an additional sheet of paper).

Injury/Surgery/Condition	Date of Onset	Treatment	Current Status

Do you have any infectious or contagious disease?

Females:----------
Are you pregnant or trying to become pregnant? Y / N
Are you currently in your menses? Y / N
Do you have difficult or painful menses? Y / N

Please list any areas you always want avoided in your massages:

Please describe your occupation and duties (include number of hours worked per week):

Please describe what you typically do to maintain your health:

How did you find out about Treatment Massage?

Client Signature: _____

Date: _____

CONTRACTUAL AGREEMENT OF PAYMENT FOR HEALTH CARE SERVICES AND DISCLOSURE STATEMENT

1. I hereby agree to pay directly to Treatment Massage such sums as may be due and owing for health care services rendered me.
2. I agree to never rescind this document and that any attempt at recession will not be honored by my attorney or any attorney engaged by me in this matter.
3. I fully understand that I am directly and fully responsible to said health care provider for all health care bills submitted for services rendered me. Further, this agreement is made solely for said health care provider's additional protection and in consideration of their forbearance on payment. I also understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages.
4. I agree to pay the full billable amount for any missed, cancelled, or rescheduled appointments for which a 24 hour notice has not been given.
5. I will pay a $35.00 fee for the first returned check and a $50.00 fee for the second and all other returned checks. This applies to returned checks for any reason, including insufficient funds.
6. I agree I am personally responsible for all fees incurred by Treatment Massage for recovery of my bill, including but not limited to; attorney fees, lien related fees, collection fees, and current hourly rate for time spent to recover my outstanding bill.
7. If my account needs to be sent to collections for nonpayment, a 100% fee of my current outstanding balance will be added to my outstanding balance to cover this service.
8. Any outstanding fees on my account that are 30 or more days past due will accrue additional late fee equal to 50% of the current outstanding balance. This fee will be assessed and added to the current balance each month on the first of the month.
9. An appointment is specifically for the time booked. If I arrive late for my appointment, it will be shorter accordingly.
10. I understand that massage practitioners do not diagnose illness, disease, or other physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. I understand that massage is not a substitute for medical examination, or diagnosis, and that it is recommended that I see a physician or nurse practitioner for any physical ailment that I might have. I have stated all my known medical conditions and I am ultimately responsible for the information I have given to the massage practitioner.
11. If I receive services at Treatment Massage and any payment is to be provided through a third party (medical insurance, auto insurance, Washington State Labor and Industries, etc.), I authorize the release of any medical or other pertinent information to process the claim. This includes information held by any insurance company, health care service contractor, health maintenance organization, Multiple Employer Welfare Arrangement, or other organization that has knowledge about me. Should my account need to be addressed by the Washington State Office of the Insurance Commissioner, I authorize all said organizations and agencies to release my medical records and related information to the Washington State Office of the Insurance Commissioner to help resolve any claim or dispute. I also authorize payment to be made directly to the therapist providing care. A photographic copy of this authorization is as valid as the original.
12. This contractual agreement replaces any prior contractual agreement I have had with Treatment Massage.

I, as a client of Treatment Massage, understand and agree to all of the above conditions, requirements, clauses, statements, etc.

Client Name (Printed): _____

Client Signature: _____

Date: _____

(Optional) Electronic Delivery of Personal Health Information (i.e. email)

I authorize Mark Pearlscott, LMT of Treatment Massage to send my personal health information, medical records, communications, etc. through the un-secured un-encrypted route of electronic transmission known as email. I accept all responsibility and liability for my information being sent through email.

Client Name (Printed): _____

Client Signature: _____

Date: _____