INDIGO FOUNTAIN **Confidential Patient Information/Registration**

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE LET ME KNOW

Name: ______________________ Age: ________ Today's date: ______________

Date of Birth: ______________ Social Security Number: ______-______-______ ☐ Male ☐ Female

Mailing Address: ______________________ City: ______________ State: ________ Zip: ________

Home Phone: (_____) __________ Cell Phone: (_____) __________ Email: ______________

Name of Spouse / Nearest Relative: Phone:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Your Occupation: ______________________

Your Employer: ______________________ Work Phone: (_____) __________

Employers Address: ______________________ City: ______________ State: ________ Zip: ________

Emergency Contact: ______________________ relationship: Phone: ______________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

☐ Friend ☐ Family ☐ Doctor's Office ☐ Yellow Pages ☐ Other Name/source: ______________

INSURANCE/BILLING INFORMATION:

Payment for Services by: ☐ Cash ☐ Check ☐ Credit Card ☐ Health Insurance ☐ Auto Policy ☐ Workers Comp

Is your Primary Insurance Policy: ☐ POS ☐ PPO ☐ EPO ☐ HMO ☐ Don't Know ☐ Other

Name of Insurance Company: ______________________ Policy or claim number: ______________

Group Number: ______________________ Policy Holder Gender: ☐ M ☐ F

Name of Insured: ______________________ Insurer's relationship to you: ______________

Insurer's Social Security Number: ______-______-______ Insurer's Date of Birth: ______________

Insurer's Employer: ______________________ Employers Phone: (_____) __________

Does your insurance have Chiropractic and/or Massage benefits? ☐ Yes ☐ No

Does your plan require you have a referral from your Primary Care Provider to receive coverage? ☐ Yes* ☐ No
*If Yes, which licensed provider were you referred to at our clinic?

Who is your Primary Care Provider? Dr.______________________ Clinic Phone: ______________

Clinic Address: ______________________ City: ______________ State: ________ Zip: ________

Secondary Insurance

Name of Insurance Company: ______________________ Policy or claim number: ______________

Name of Insured: ______________________ Insurer's relationship to you: ______________

Insurer's Social Security Number: ______-______-______ Insurer's Date of Birth: ______________

Insurer's Employer: ______________________ Employers Phone: (_____) __________

If Injury - Date of Injury: ______________ Caused by: ______________________

Attorney Name: ______________________

Thank you for choosing my clinic for your healthcare needs. We are committed to providing you the highest quality care available by our providers and staff. Please sign below to allow our medical billing facility to submit your claims to your insurance companies. Any services not paid by your insurance company will become your responsibility. All co-payments are due at the time of your appointment or our billing personnel will send you a statement for any remaining balances owing on your account.

Patient / Guardian Signature: ______________________

What do you hope to accomplish from today's massage? ______________________________

Are you aware of any tension holding spots in your body? __________ If yes, location(s): ______________________________

____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: ______________________________

More than 5 years ago: ______________________________

What kind of care did you receive for your accidents or injuries? ______________________________

Do you feel that you have recovered from these events? __________ Please explain: ______________________________

____

Do you have any chronic, ongoing pain that you deal with on a regular basis? ______________________________

Please explain: ______________________________

Is this your first professional massage? __________ If no, how frequently do you get a massage? ______________________________

Descripbe what activities cause this pain and/or make it worse: ______________________________

Are you receiving any other type of medical treatment? __________ Please explain: ______________________________

Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat):

____

____

Are you currently under the care of a physician? __________ Whom? ______________________________

Please list reason(s): ______________________________

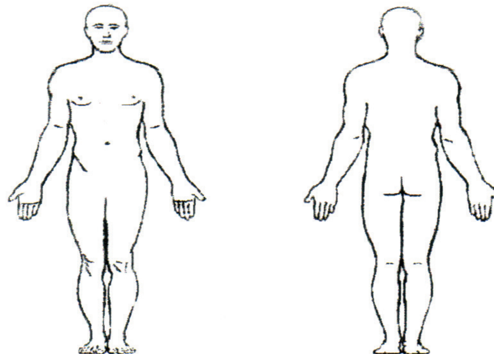
Are there any other health concerns you wish to discuss today? __________ If yes, please describe: ______________________________

____

Are you currently experiencing any of the following conditions?

______ Flu or Cold ______ Inflammation ______ Fever ______ Infection ______ Contagious Disease

Please indicate where you experience pain on the drawing below.



Please check any of the following conditions below
that currently affect you or that you have experienced in the last 5 years.

MUSCULOSKELETAL
___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis
___ Postural Deviations
___ Gout
___ Osteoarthritis/Rheumatoid Arthritis
___ TMJ
___ Cysts
___ Bursitis
___ Plantar Fascitis
___ Tendonitis
___ Torticollis
___ Whiplash Syndrome
___ Carpal Tunnel Syndrome
___ Sciatica
___ Thoracic Outlet Syndrome
___ Headache
___ Leg Pain
___ Arm Pain/Shoulder Pain
___ Low Back Pain
___ Mid Back Pain
___ Hip Pain
___ Other ____________________

RESPIRATORY
___ Pneumonia
___ Sinusitis
___ Asthma
___ Trouble Breathing
___ Dizziness
___ Other____________________

CIRCULATORY
___ Anemia
___ Hemophilia
___ Hypertension
___ Low Blood Pressure
___ Raynaud's Disease
___ Varicose Veins
___ Heart Condition
___ Blood Clots/Phlebitis
___ Diabetes
___ Other ________________

DIGESTIVE
___ Ulcers
___ Irritable Bowel Syndrome
___ Colitis
___ Gallstones
___ Hepatitis
___ Crohn's Disease
___ Diarrhea
___ Gas/Bloating
___ Indigestion
___ Other__________________

SKIN
___ Fungal Infections
___ Acne
___ Impetigo
___ Dermatitis/Eczema
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts/Moles
___ Athletes Foot
___ Other ____________________

NERVOUS SYSTEM
___ ALS
___ Multiple Sclerosis
___ Parkinson's Disease
___ Bell's Palsy
___ Neuritis
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Seizure Disorders
___ Numbness/Tingling/Twitching
___ Other ________________

OTHER
___ Insomnia
___ Anxiety/Panic Attacks
___ PMS
___ Grief Process
___ Cancer
___ Substance Abuse
___ Pregnancy
___ Chronic Fatigue
___ HIV/AIDS
___ Lupus
___ Kidney Disease
___ Bladder Infection
___ Postoperative Situation
___ Edema
___ Other________________

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

Sign and date: ____

HIPAA / OFFICE COMPLIANCE

At Indigo Fountain Therapeutic Massage, we provide confidentiality for your personal health information and compliance with all aspects of administration to ensure your privacy and health care are treated with the utmost importance.

Please read each section below and initial next to all items indicating you have read and understand your rights and responsibilities as further outlined in the Office Policies revision form IF042010 given to me by Indigo Fountain Therapeutic Massage.

Consent to Treat: I have read and fully understand the TERMS OF ACCEPTANCE and hereby grant permission for me and/or my child to receive massage care. All questions regarding the LMP's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept massage care on this basis.

Initials ________________

Financial Agreement: I understand that I am responsible for all co-payments, deductibles and charges for services rendered to me not covered by my insurance company. I will pay my co-payments at the time of service per contractual obligation with my insurance company. Balance over 60 days may incur a billing fee of 1.5%per month. I understand that delinquencies on my account may result in my account being turned over to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts.

Initials ________________

Attendance Agreement: My initials acknowledge that I understand that there is a $25 fee payable by me for a weekday appointment ($75 for Saturday appointments) if I do not give this clinic 24 hour notice for cancellation or no show of my scheduled appointment.

Initials ________________

Release of Benefits and Information: I authorize my insurance benefits be paid directly to the provider of service. I am financially responsible for any copays or balance due. I authorize INDIGO FOUNTAIN to release any information required for claims to be paid for services rendered.

Initials ________________

Acknowledgement Receipt of Notice of Privacy Practices: My initials indicate that I have received/ reviewed the privacy practices implemented by Indigo Fountain Therapeutic Massage, I also understand that I can allow or disallow any individuals from viewing or requesting my medical records. I DO NOT want the following individuals accessing my personal health information:

Initials ________________

I have received a copy of the OFFICE POLICIES revision number IF042010.

Initials ________________

Signature:____________________ Initials: ________________ Date: ________________