

**Spinal & Sports Care Clinic, PS**  
12905 E Sprague Ave., Spokane Valley, WA 99216

First Name (Legal): \_\_\_\_\_ (MI): \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number: \_\_\_/\_\_\_/\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Married  Single  Other

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

May we leave a message if we need to?  Yes  No E-mail address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Patient Employer/School: \_\_\_\_\_

Military:  Active  Veteran  N/A Who may we thank for referring you? \_\_\_\_\_

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**In Case of Emergency Contact**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_

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**Insurance Information**

Who is responsible for this account?: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Primary Insurance Company:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_/\_\_\_/\_\_\_

Insurance ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Phone Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_/\_\_\_/\_\_\_

Insurance ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Number: \_\_\_\_\_

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*I understand it is my responsibility to provide Spinal & Sports Care Clinic with accurate information concerning my insurance coverage and personal information. I understand that all quotes are an estimate and all balances are subject to the information Spinal and Sports Care Clinic received from my insurance carrier. I understand there are no guarantees of benefits and I am financially responsible for all charges rendered whether or not paid by my insurance. I authorize Spinal & Sports Care Clinic the use of my signature on all insurance submissions. I also authorize Spinal & Sports Care Clinic to provide information to my insurance carrier(s) and their agents for the purpose of obtaining payment for services rendered and assign directly to Spinal & Sports Care Clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand Spinal & Sports Care Clinic will not become involved in any dispute between me and my insurance company. It will be my responsibility to settle any such dispute.*

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Print Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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Signature of patient/parent/guardian/personal representative \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

*Massage Intake Form*

Name \_\_\_\_\_ Date \_\_\_\_\_  
 Street \_\_\_\_\_ Home Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
 Primary Health Insurance \_\_\_\_\_

***Massage History / Treatment Information***

Have you ever received a professional massage? **Yes** **No** Date of last Massage \_\_\_\_\_  
 What results do you want from your massage sessions? \_\_\_\_\_

Are there any areas of your body that you do not want massaged?  
 \_\_\_\_\_ Head \_\_\_\_\_ Arms/Shoulders \_\_\_\_\_ Neck/Upper Body  
 \_\_\_\_\_ Abdomen \_\_\_\_\_ Low Back/Buttocks \_\_\_\_\_ Legs \_\_\_\_\_ Feet

List any exercises or activities that makes your condition **better**: \_\_\_\_\_

List any exercises or activities that make your condition **worse**: \_\_\_\_\_

List current medications including aspirin, ibuprofen, herbal remedies, etc. \_\_\_\_\_

Are you currently under the care of a medical doctor? Yes No  
 If yes, please give name \_\_\_\_\_

***Previous History (Include year and treatment received)***

Surgeries: \_\_\_\_\_

Injuries/accidents still affecting you:  
 \_\_\_\_\_  
 \_\_\_\_\_

Major Illnesses or Hospitalizations: \_\_\_\_\_

Please turn page over and complete form

Please mark any of the following that you now have or have had. **Circle** applicable condition where two are listed on same line and indicate left or right side and location where needed.

### Musculoskeletal

- Bone or joint disease
- Tendonitis / Bursitis \_\_L \_\_R \_\_\_\_\_
- Arthritis / Gout / Blood Clots
- Sprains / Strains \_\_L \_\_R \_\_\_\_\_
- Low back / hip / leg pain \_\_L \_\_R \_\_\_\_\_
- Neck / shoulder / arm pain \_\_L \_\_R \_\_\_\_\_
- Spasms / cramps
- Jaw pain (TMJ)
- Lupus
- Osteoporosis
- Other: \_\_\_\_\_

### Circulatory

- Heart condition
- Phlebitis / Varicose Veins
- Blood Clots
- High / Low Blood Pressure
- Lymphedema
- Thrombosis / Embolism
- Other : \_\_\_\_\_

### Respiratory

- Breathing difficulty / asthma
- Emphysema
- Allergies
- Sinus Problems
- Other: \_\_\_\_\_

### Skin

- Allergies
- Rashes
- Athletes foot
- Herpes / cold sores
- Other: \_\_\_\_\_

### Digestive

- Constipation
- Gas / bloating
- Diverticulitis
- Irritable bowel syndrome
- Ulcers

- Other: \_\_\_\_\_

### Reproductive

- Pregnant: Stage
- Ovarian / menstrual problems
- PMS
- Prostate
- Other: \_\_\_\_\_

### Nervous

- Shingles
- Numbness / tingling \_\_L \_\_R \_\_\_\_\_
- Trigeminal / Neuralgia
- Bell's Palsy
- Pinched Nerve
- Other: \_\_\_\_\_

### Other

- Cancer / Tumors
- Bladder / Kidney ailment
- Diabetes
- Drug / Alcohol / Caffeine / Tobacco use
- Chronic fatigue
- Chronic pain
- Sleep disorders
- Migraines / Headaches
- Anxiety / Stress syndrome

### Please circle all that apply today:

- Contact lenses (hard or soft?)
- Infection
- Inflammation / swelling
- Fever
- Communicable illness (please specify):  
\_\_\_\_\_

### Additional Client Remarks / Comments

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Massage therapists must be aware of any existing physical conditions that I have. I have listed all my known medical conditions and physical limitations and will inform the massage therapist in writing of any change in my physical health. I understand that a massage therapist neither diagnoses illness, disease, or any other medical, physical, or emotional disorder, nor performs any spinal manipulations. I am responsible for consulting a qualified physician for any physical ailment that I have. I also agree to give 24-hour notice if I must cancel my appointments for these sessions.

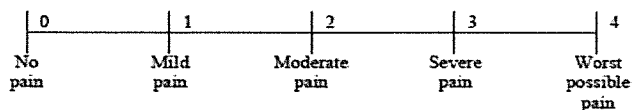
Signed \_\_\_\_\_ Date \_\_\_\_\_

# Functional Rating Index

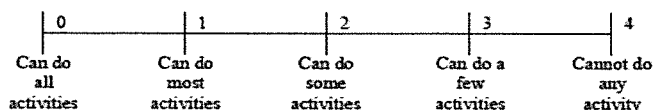
For use with Neck and/or Back Problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems has affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

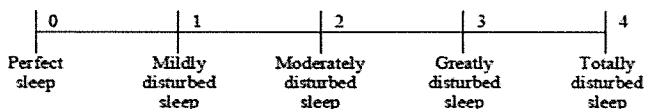
## 1. Pain Intensity



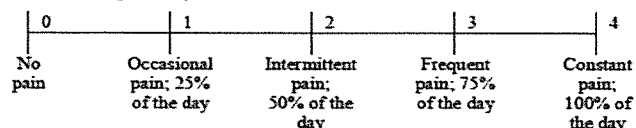
## 6. Recreation



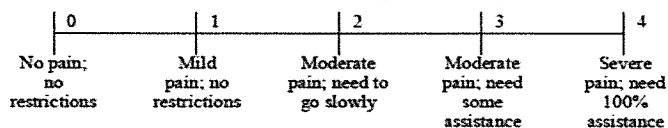
## 2. Sleeping



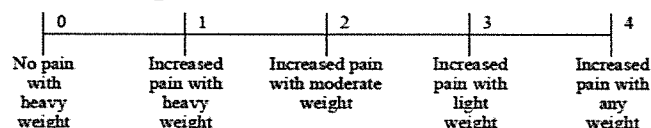
## 7. Frequency of Pain



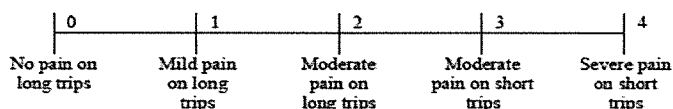
## 3. Personal Care (washing, dressing, etc.)



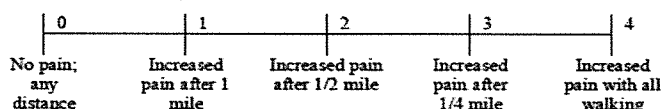
## 8. Lifting



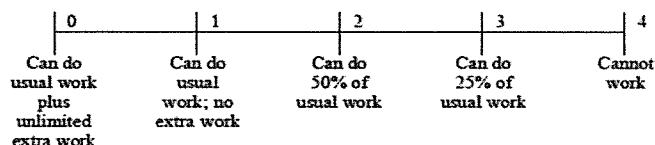
## 4. Travelling (driving, etc.)



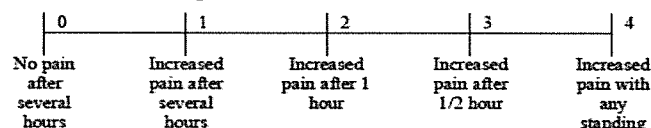
## 9. Walking



## 5. Work



## 10. Standing



\_\_\_\_\_  
 Patient's Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please Print Name

Rate your current level of pain by checking one of these numbers.

Primary Complaint: <input type="checkbox"/> Neck <input type="checkbox"/> Mid Back <input type="checkbox"/> Low	0	1	2	3	4	5	6	7	8	9	10
Secondary Complaint: <input type="checkbox"/> Neck <input type="checkbox"/> Mid Back <input type="checkbox"/> Low Back	0	1	2	3	4	5	6	7	8	9	10

**Office Use Only:**

Total Score: \_\_\_\_\_ /40 = \_\_\_\_\_ %      Today's \_\_\_\_\_ % vs. Previous \_\_\_\_\_ %

Percentage of Improvement \_\_\_\_\_ %

**MESSAGE CLINIC POLICIES**

**Financial Policy:**

\_\_\_\_\_ I understand that I will be required to pay for my massage services at the time of my appointment.

\_\_\_\_\_ I understand that my insurance will be billed for massage therapy services and that I will pay all deductible and patient responsibility payments prior to seeing the therapist. I also understand that if my insurance denies payment for any reason, I will be responsible for the balance due on my services at that time. Any dispute with the insurance company regarding covered services will be my responsibility to resolve.

\_\_\_\_\_ I understand that if a referral/prescription from my treating physician is required by my insurance, our clinic will make every effort to *assist* me in obtaining it. However, if the referral is not in place at the time of my visit I will be rescheduled. A referral or prescription does not guarantee insurance payment. All services billed to insurance are based upon medical necessity to be determined by the insurance company upon receipt of your claim for services provided.

\_\_\_\_\_ *If I am unable to pay at the time of service, I will be rescheduled for a more convenient time.*

\_\_\_\_\_ I understand that any massage benefit information given to me by the staff at SSCC is an *ESTIMATE* only of benefits as quoted to them by the insurance company. The office does not guarantee the correctness of the information. It is my responsibility to know and understand my massage benefit.

**No Show Policy:**

\_\_\_\_\_ Our clinic requires a 24-hour notice for cancellation of all massage appointments. If I am unable to give this notice or I fail to keep my appointment I will be charged a "No Show" fee which will be expected to be paid within 24 hours and prior to scheduling any future appointments. *The no show fee for massage therapy is \$65.00. This is not billable to insurance, and is my responsibility to pay. Should I have a third "no show", I will be required to pay in advance for any future massage appointment at the time of scheduling. Insurance companies will not be billed for missed (no show) appointments.*

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## PATIENT AUTHORIZATION FOR RELEASE OF PHI

Patient Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Chart Number \_\_\_\_\_

**By signing this form, I authorize Spinal and Sports Care Clinic PS to use and/or disclose my:**

- **Protected Health Information (PHI):** PHI means information about a patient, including demographic information that may identify a patient, that relates to the patient's past, present or future physical or mental health or condition, related health care services or payment for health care services
- **Sensitive Protected Health Information (SPHI):** SPHI means Protected Health Information that pertains to particularly sensitive information, as defined by state law, such as (i) an individual's HIV status or treatment of an individual for an HIV-related illness or AIDS, or (ii) an individual's substance abuse condition or treatment of an individual for mental illness.

**I authorize disclosure of the following information from my medical record:**

*Note: Include a detailed description of information to be released including dates.*

\_\_\_\_\_  
\_\_\_\_\_

**Release medical records to my medical provider or attorney listed below:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address \_\_\_\_\_

**I authorize Spinal & Sports Care Clinic to provide information regarding my personal information such as appointments, bills, or general account information to: (spouse, partner, parent, etc.)**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address \_\_\_\_\_

**(Spinal & Sports Care Clinic, by law, cannot speak to anyone regarding personal information unless we are authorized by you to do so!)**

**I Understand that:**

- Treatment will not be conditional on whether I sign this Authorization.
- This Authorization is voluntary and that I have the right to refuse to sign it.
- If I sign this authorization, I may revoke it later by sending a written notice of revocation to the privacy office at the practice.

*Note: The only exception to your right to revoke is if the practice has already acted in reliance upon the authorization.*

- Once signed, the Practice will provide me with a copy of this Authorization.  
By signing this form below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
- Conduct, plan and direct my treatment and follow-up among the health care providers who may be

directly and indirectly involved in providing my treatment.

- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

By signing this form below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and accreditation.

**Signature(s)**

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Sign below if you are a personal representative of the patient.

Representative signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

**For Office Use Only**

**Verification Method:** \_\_\_\_\_

**We attempted to obtain written Acknowledgment of receipt of our Notice of Privacy Practices, but Acknowledgment could not be obtained because:**

- Individual refused to sign
- Communications barriers prohibited obtaining the Acknowledgment
- An emergency situation prevented us from obtaining Acknowledgment
- Other (Please Specify) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Staff signature

\_\_\_\_\_  
Date

**Patient Name:** \_\_\_\_\_ **Date of Service:** \_\_\_\_\_ - \_\_\_\_\_

### Advance Beneficiary Notice of Non-Coverage (ABN)

Your current Health Plan has determined that Massage Therapy maintenance treatment that doesn't produce lasting improvement is a non-covered benefit. ***This includes monthly therapeutic care to control chronic pain.*** If your Health Plan deems your treatment as non-covered or not medically necessary, you may be responsible for payment. The services indicated below may not be a covered service if not considered as medically necessary treatment.

Indicated Service(s) and Cost	Reason My Health Plan May Not Pay
Therapeutic Massage <input checked="" type="checkbox"/> 97124 - \$110.00	Therapeutic Massage must be medically necessary and meet the guidelines of the Health Plan.

**OPTIONS: Check only one box. We cannot choose a box for you.**

**OPTION 1.** I want the indicated service(s) listed above whether or not my therapist considers it not medically necessary. I understand that Spinal & Sports Care Clinic will continue to submit a bill to my Health Plan on my behalf in order to receive an official determination of payment. I understand that if it is determined that my services are not considered a covered benefit or not deemed medically necessary, I am responsible for payment in full in which it is within my rights to submit an appeal to my Health Plan as indicated in my benefit booklet.

If at any time my Health Plan audits services in which they have already made payment, I will be responsible for past services deemed not covered or medically necessary. Initials: \_\_\_\_\_

**OPTION 2.** I want the indicated service(s) listed above when my therapist deems it medically necessary, but do not bill my Health Plan if my therapist deems it not medically necessary. You may ask for payment now when I am responsible for services rendered. **I cannot appeal if my Health Plan is not billed.**

**Additional Information:**

For questions or concerns regarding your benefits such as, amounts, limitations, and policy guidelines, please contact your Health Plan's Customer Service at the number listed on the back of your member's ID card.

Signing below means that you have received and understand this notice. You will receive a copy upon request.

<b>Signature:</b> _____	<b>Signed Date:</b> _____
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Account # \_\_\_\_\_

Reviewed with patient by: \_\_\_\_\_