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? _____

In Case of Emergency Contact

Name: _____ Relationship to patient: _____

Phone Number: _____ Work Number: _____

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: _____

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.

_____

Print Patient Name Date

_____

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

Spinal & Sports
CARE CLINIC
Soothing relief for your worst pain

Paul Kays, LMP
Amanda Jacobs, LMP
Suzi Doan, LMP
Cheryl Bullis, LMP
Janae Klemetsen, LMP

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 Hospitializations:_____

Please turn page over and complete form

12905 E. Sprague Ave, Spokane Valley, WA 99216 • (509) 922-0303

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

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

Circulatory

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

Respiratory

- o Breathing difficulty / asthma
- o Emphysema
- o Allergies
- o Sinus Problems
- o Other: _____

Skin

- o Allergies
- o Rashes
- o Athletes foot
- o Herpes / cold sores
- o Other: _____

Digestive

- o Constipation
- o Gas / bloating
- o Diverticulitis
- o Irritable bowel syndrome
- o Ulcers
- o Other: _____

Reproductive

- o Pregnant: Stage
- o Ovarian / menstrual problems
- o PMS
- o Prostate
- o Other: _____

Nervous

- o Shingles
- o Numbness / tingling __L __R _____
- o Trigeminal / Neuralgia
- o Bell's Palsy
- o Pinched Nerve
- o Other: _____

Other

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

Please circle all that apply today:

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

_____

Additional Client Remarks / Comments

_____

_____

_____

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

0	1	2	3	4
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0	1	2	3	4
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

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

0	1	2	3	4
No pain; no restrictions	Mild pain; no restrictions	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance

4. Travelling (driving, etc.)

0	1	2	3	4
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0	1	2	3	4
Can do usual work plus unlimited extra work	Can do usual work; no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0	1	2	3	4
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activity

7. Frequency of Pain

0	1	2	3	4
No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of the day	Frequent pain; 75% of the day	Constant pain; 100% of the day

8. Lifting

0	1	2	3	4
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0	1	2	3	4
No pain; any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking

10. Standing

0	1	2	3	4
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

_____

Patient's Signature

_____

Date

_____

Please Print Name

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

Primary Complaint: ❑ Neck ❑ Mid Back ❑ Low	0	1	2	3	4	5	6	7	8	9	10
Secondary Complaint: ❑ Neck ❑ Mid Back ❑ 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 _____%

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MASSAGE 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

Spinal and Sports Care, PS
12905 E Sprague Ave, Spokane Valley, WA 99216
Phone (509) 922-0303 Fax (509) 922-0657

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**

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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 ☒ **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.

Signature:	**Signed Date:**

Account # _____ Reviewed with patient by: _____