Massage Therapy Treatment Questionnaire

Patient Name: _____ **Visit Date:** _____

Your insurance has implemented a medical necessity review process that requires this information to ensure their members are receiving appropriate care and to assist them in managing your benefits.

Medical necessity is defined as:

- Significant, lasting therapeutic benefits that lead towards a *resolution* of the patient's complaints.
- Functional improvement as the result of massage therapy treatment
- Patient must have at least one functional limitation AND at least one pain complaint.

Please note: Massage Therapy for Preventive, Maintenance or Wellness Care is *NOT* considered medically necessary by the guidelines listed above and therefore not a covered benefit of your plan.

Please answer the questions listed below to the best of your ability to help us establish medical necessity and obtain authorization from your insurance carrier for your massage therapy treatment today.

Please check which applies to today's visit:

☐ I have ***not*** had massage therapy treatment in the past 60 days.

☐ I am seeking treatment for additional care of the same condition treated within the last 60 days.
What is the result of your continuing care? ☐ ***Improving*** ☐ ***Same*** ☐ ***Worse***
How long did the pain relief last from my last visit? _____ ***days***

☐ I am seeking treatment for a new or different condition from my last visit.
What was the result of your previous treatment? ☐ ***Resolved*** ☐ ***Ongoing***

How long have you had this condition? ☐ 0-5 weeks ☐ 6-12 weeks ☐ over 12 weeks ☐ unknown

What is your pain intensity today? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What percentage of time do you experience the pain? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

What is your primary area of complaint? On a scale of 0-5 (0 = no pain, 5 = severe pain), please indicate pain level for each area of the body. ___ Head/Cervical Spine ___ Upper Back/Thoracic Spine
___ Lower Back/Lumbar Spine ___ R / L Arm ___ R / L Leg ___ Other_____

On a scale of 0-4 (0 = no pain, 4 = severe pain), please indicate your functional deficits associated with your pain.

Standing:	0	1	2	3	4	Driving:	0	1	2	3	4
Walking:	0	1	2	3	4	Recreation:	0	1	2	3	4
Lifting:	0	1	2	3	4	Work:	0	1	2	3	4
Sleeping:	0	1	2	3	4	Housework:	0	1	2	3	4
Sitting:	0	1	2	3	4	Yardwork:	0	1	2	3	4
Climbing Stairs:	0	1	2	3	4	Personal Care:	0	1	2	3	4

Patient Signature _____ Date: _____

Office Use ONLY: ____ Post Pain Intensity ____ % of Time experiencing pain

Spinal & Sports
CARE CLINIC
Soothing relief for your worst pain

Steven Shirley, D.C., CCSP
W. Jack Choate, D.C.
Brittany Rush, D.C.
Sylvia Tripp, DC

Referral/Authorization Waiver

☐ It has been explained to me and I fully understand that my insurance carrier requires me to have a referral and/or authorization from my provider for all services rendered at this office. I also understand and agree if I do not have a referral and/or authorization in place at the time of my appointment(s) I will be responsible for all services rendered should it be denied.

Liability Acknowledgment

☐ It has been explained to me and I fully understand that I am financially responsible for charges and/or balances that are not covered by my insurance. This includes (but is not limited to) all deductibles, coinsurance, and copays. I understand that I am also responsible for any services that my insurance may deem not medically necessary and/or not a covered benefit for my plan.

This waiver begins today and expires December 31, 2017

_____
Account #

_____ _____
Patient Name Date

_____
Patient and/or Guarantor Signature