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.

<table>
<thead>
<tr>
<th>Indicated Service(s) and Cost</th>
<th>Reason My Health Plan May Not Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Massage 97124 $112.00</td>
<td>Therapeutic Massage must be medically necessary and meet the guidelines of the Health Plan.</td>
</tr>
</tbody>
</table>

**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, but do not bill my Health Plan when my provider deems my service does not meet medical improvement guidelines. Only bill for services that are deemed medically necessary by my provider. You may ask for payment now as 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:** __________________________
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 = No pain
   - 1 = Mild pain
   - 2 = Moderate pain
   - 3 = Severe pain
   - 4 = Worst possible pain

2. **Sleeping**
   - 0 = Perfect sleep
   - 1 = Mildly disturbed sleep
   - 2 = Moderately disturbed sleep
   - 3 = Greatly disturbed sleep
   - 4 = Totally disturbed sleep

3. **Personal Care (washing, dressing, etc.)**
   - 0 = No pain; no restrictions
   - 1 = Mild pain; no restrictions
   - 2 = Moderate pain; need to go slowly
   - 3 = Severe pain; need some assistance
   - 4 = Severe pain; need 100% assistance

4. **Travelling (driving, etc.)**
   - 0 = No pain on long trips
   - 1 = Mild pain on long trips
   - 2 = Moderate pain on long trips
   - 3 = Severe pain on long trips
   - 4 = Severe pain on short trips

5. **Work**
   - 0 = Can do usual work plus unlimited extra work
   - 1 = Can do usual work
   - 2 = Can do 50% of usual work
   - 3 = Can do 25% of usual work
   - 4 = Cannot work

6. **Recreation**
   - 0 = Can do all activities
   - 1 = Can do most activities
   - 2 = Can do some activities
   - 3 = Can do a few activities
   - 4 = Cannot do any activity

7. **Frequency of Pain**
   - 0 = No pain
   - 1 = Occasional pain: 25% of the day
   - 2 = Intermittent pain: 50% of the day
   - 3 = Frequent pain: 75% of the day
   - 4 = Constant pain: 100% of the day

8. **Lifting**
   - 0 = No pain with heavy weight
   - 1 = Increased pain with moderate weight
   - 2 = Increased pain with light weight
   - 3 = Increased pain with any weight

9. **Walking**
   - 0 = No pain; any distance
   - 1 = Increased pain after 1/4 mile
   - 2 = Increased pain after 1/2 mile
   - 3 = Increased pain after 1 mile
   - 4 = Increased pain with all walking

10. **Standing**
    - 0 = No pain after several hours
    - 1 = Increased pain after several hours
    - 2 = Increased pain after 1 hour
    - 3 = Increased pain after 1/2 hour
    - 4 = Increased pain with all standing

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**Patient’s Signature**

**Date**

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Please Print Name

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**Primary Complaint:**
- Neck
- Mid Back
- Low

**Secondary Complaint:**
- Neck
- Mid Back
- Low Back

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**Office Use Only:**

Total Score: _______/40 = ________%  
Today’s ________% vs. Previous ________%

Percentage of Improvement ________%
HIPPA AUTHORIZATION

Patient Name_________________________________________ Date of Birth: ________________

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 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.*

• 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_________________________________________ Date ______________________

Relationship to Patient__________________________________________________________

For Office Use Only

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 prevented us from obtaining Acknowledgment
☐ Other (Please Specify) ______________________________________________________

Staff signature_________________________________________ Date____________________
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 ________________________________
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
  ____________________________________________
  ____________________________________________

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 ____________________________
**Massage Intake Form**

Name ________________________________________________    Date _________________________

Street ________________________________________________    Home Phone __________________

City ___________________ State _____________ Zip _______

Work Phone ___________________

Occupation ___________________________________________    Date of Birth __________________

Emergency Contact _____________________________________    Phone (_____) _________________

Primary Health Insurance _____________________________________________

<table>
<thead>
<tr>
<th>Massage History / Treatment Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever received a professional massage? <strong>Yes</strong> No Date of last Massage __________________</td>
</tr>
<tr>
<td>What results do you want from your massage sessions? ____________________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Are there any areas of your body that you do not want massaged?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head                                           Arms/Shoulders</td>
</tr>
<tr>
<td>Abdomen                                        Low Back/Buttocks</td>
</tr>
<tr>
<td>Legs                                           Feet</td>
</tr>
</tbody>
</table>

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

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

Patient Name: ___________________________ Date of Birth: ___________________________

By signing this form, I authorize Spinal and Sports Care Clinic PS to discuss health information, in person or by telephone, with the following family members or persons directly involved in my medical care.

NAME (please print): __________________________ PHONE NUMBER: __________________________ RELATIONSHIP: __________________________

NAME (please print): __________________________ PHONE NUMBER: __________________________ RELATIONSHIP: __________________________

I AUTHORIZE THIS COMMUNICATION TO INCLUDE:

☐ All health care information
☐ Health care information relating to the following treatment/condition: __________________________
☐ Health care information in my medical records for the date(s): __________________________
☐ Other (i.e. x-rays, bills, etc) specify date/item(s): __________________________
☐ Can schedule and reschedule appointments on my behalf

I UNDERSTAND THAT THIS AUTHORIZATION IS:

• Limited to verbal and telephone conversations and does not permit or authorize the release of any written health information to any of the individuals named above.
• Limited to the specific timeframe determined by me and that if I do not specify a specific timeframe, this authorization will remain in effect until it is revoked in writing.

I further understand that if I do not want verbal discussion to be permitted between my health care provider and the individual(s) named above, I have the right to revoke this authorization in writing at any time. I understand that this written revocation will not affect any disclosures of my medical information that the person and/or organization listed on this authorization that have already made, in reliance on this authorization before the time I revoke it.

This document has been explained to me and all my questions have been answered satisfactorily.

________________________________________   ____/____/___________
(Signature of patient or legal representative)   (Date)

________________________________________
(Relationship to patient)

This authorization is NOT valid unless it is signed and date by the patient or their representative.
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