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

Massage Intake Form

Patient Information:

Patient Name _____ Date of Birth _____ Date _____

Massage History / Treatment Information:

Have you ever received a professional massage? **YES** **NO** Date of last Massage: _____

Please mark any areas of your body that you **DO NOT** want massaged:

O Head	O Jaw	O Neck	O Upper Arms	O Lower Arms	O Hands
O Shoulders	O Chest	O Abdomen	O Upper Legs	O Lower Legs	O Feet
O Upper Back	O Mid Back	O Low Back	O Hips	O Buttocks	

What results do you want from your massage sessions?

_____

List any exercises or activities that make 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** Doctor Name:_____

Previous History (include year and treatment received):

Surgeries:

_____

Injuries/accidents still affecting you:

_____

Major Illnesses or Hospitalizations:

_____

12905 E Sprague Ave Spokane Valley WA 99216-0731 | Phone (509)-922-0303 | Fax (509) 922-0657

Steven Shirley, DC, CCSP
W. Jack Choate, DC
Brittany C. Rush, DC
Kenneth Van Dyken, DC

Spinal & Sports CARE CLINIC

Informed Consent - Massage

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 Location:_____
- O Arthritis / Gout / Blood Clots
- O Sprains / Strains
  L R Location:_____
- O Low back / hip / leg pain
  L R Location:_____
- O Neck / shoulder / arm pain
  L R Location:_____
- 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 Location:_____
- 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
- 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 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.

Print Name _____

Signature_____ Date _____

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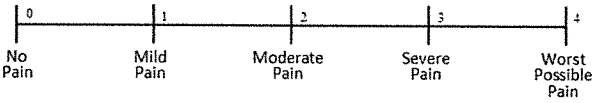
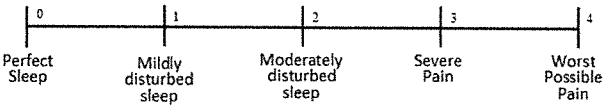
Functional Rating Index
For use with **Neck and/or Back Problems Only**

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

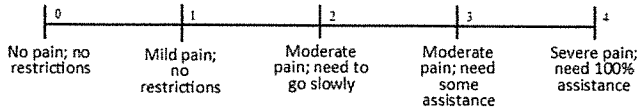
1. Pain Intensity



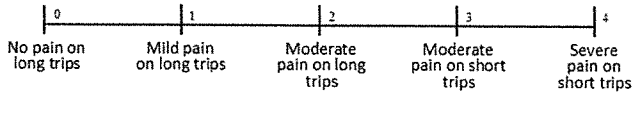
2. Sleeping



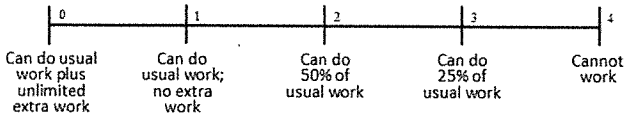
3. Personal Care (washing, dressing, etc.)



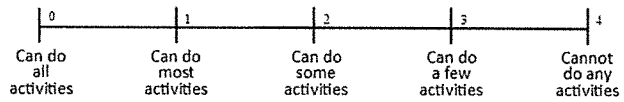
4. Travel (driving, etc.)



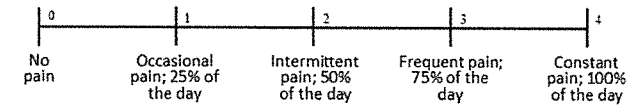
5. Work



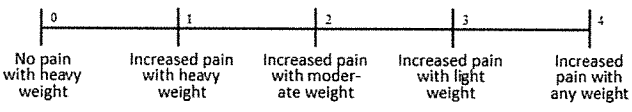
6. Recreation



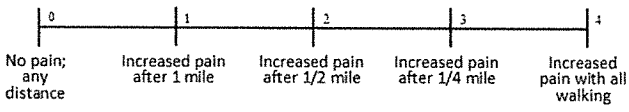
7. Frequency of pain



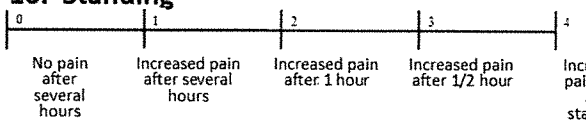
8. Lifting



9. Walking



10. Standing



Name (Printed) _____

Signature _____ **Date** _____

Total Score: _____

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

Primary Complaint ❑ Neck ❑ Mid Back ❑ Low Back	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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Financial Policy - Massage

Please read and initial *all of the following*:

_____ Payment Methods
We accept cash, checks, CareCredit, Visa, MasterCard, American Express, Discover, and debit cards.

_____ Time of Service
I understand that I will be required to pay for my massage services at the time of my appointment. If I am unable to pay at the time of service, I will be rescheduled for a more convenient time.

_____ 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 $67.00. 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.

_____ Referrals and Prescriptions
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.

Please read and initial *any that apply*:

_____ Insurance
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 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. 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.

_____ Motor Vehicle Accident
You will not be responsible for paying at time of service if you have a personal injury protection coverage plan we can bill for your care. If you've exhausted your personal injury protection coverage you will be financially responsible for all charges rendered whether or not paid by the insurance carrier.

_____ Workman's Compensation/Self Insured/Federal
You will not be responsible for paying at time of service if you have an open L&I claim or filing for L&I. If your L&I claim has been denied or closed within the course of treatment you are financially responsible for all charges rendered whether or not paid by L&I.

I have read and understand the above terms and I accept full responsibility for the services incurred with Spinal and Sports Care Clinic.

Print Name _____

Signature_____ Date _____

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Spinal & Sports
CARE CLINIC

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:

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

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**_____

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Spinal & Sports
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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 disucussion 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.