# New Patient-Massage Intake Form

ELITE MOVEMENT
Chiropractic Clinic

**Personal Information**

Name _____ Phone _____ DOB _____

Address _____ City/State/Zip _____

Occupation _____ Employer _____

Email _____ Primary Physician _____

Emergency Contact _____ Relationship _____ Phone _____

How did you hear about us?_____

**Medical Information**

Are you taking any medications? ☐ yes ☐ no If yes, please list name and use: _____

Are you currently pregnant? ☐ yes ☐ no If yes, how far along? _____ Any high risk factors? _____

Do you suffer from chronic pain? ☐ yes ☐ no If yes, please explain _____

What makes it better? _____

What makes it worse? _____

Have you had any orthopedic injuries? ☐ yes ☐ no If yes, please list: _____

Please indicate any of the following that apply to you.

| | | |
|---|---|---|
| ☐ Cancer | ☐Sprains or Strains | ☐ Numbness |
| ☐ Headaches/Migraines | ☐ Blood Clots | ☐ Kidney Dysfunction |
| ☐ Arthritis | ☐ Heart Attack | ☐ Stroke |
| ☐ Diabetes | ☐ Fibromyalgia | ☐ Neuropathy |
| ☐ Joint Replacement(s) | ☐ High/Low Blood Pressure | |

Explain any conditions you have marked above: _____

**Massage Information**

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking? ☐ Relaxation ☐ Therapeutic/Deep Tissue ☐ Other_____

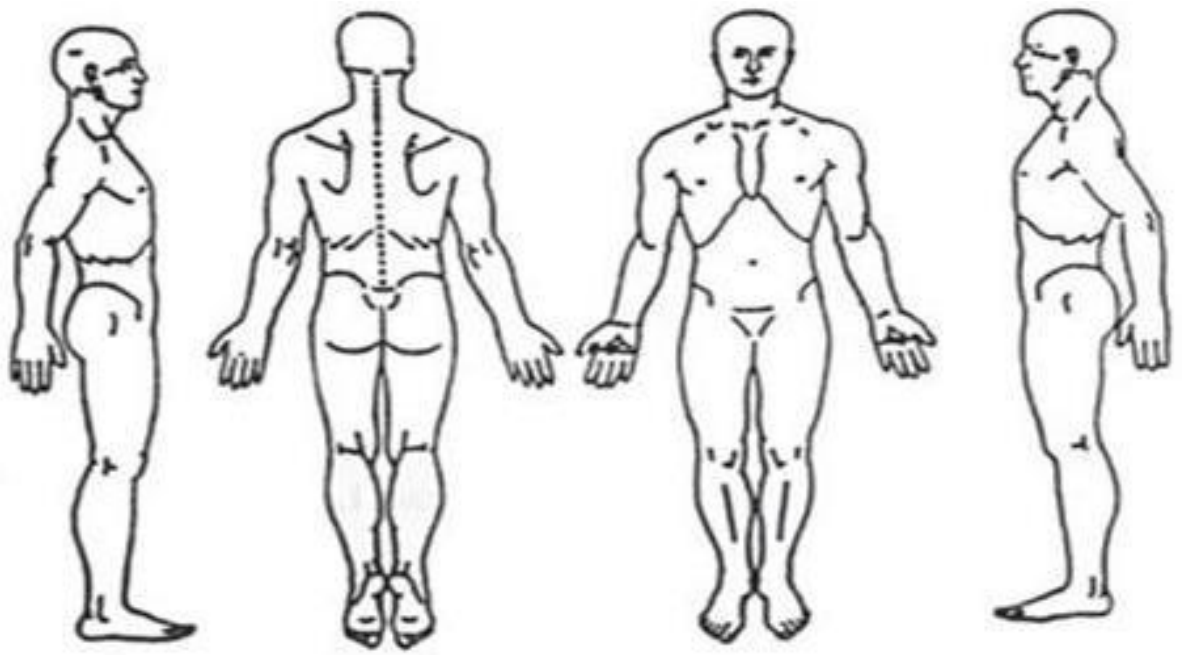
What pressure do you prefer? ☐ Light ☐ Medium ☐ Deep

Please identify any allergies or sensitivities: _____

Please identify any areas (feet, face, abdomen, etc.) you do not want massaged: _____

What are your goals for this treatment session?: _____

**Please circle any areas of discomfort**



Additional remarks:

_____

_____

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By signing below, you agree to the following:

*I have completed this form to the best of my ability and knowledge, and agree to inform my therapist if any of the above information changes at any time.*

Patient Signature: _____ Date: _____

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## NOTICE OF EMCC PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### YOUR RIGHTS

- Get an electronic or paper copy of your medical record- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- ONLY if you pay for a service or health care item out-of-pocket, in full, at the time of service, can we comply with your request not to share that information for the purpose of payment or our operations with your health insurer. (i.e. - comply with your request not to file your claims to your insurance company). Otherwise, we will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you - If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated- You can complain if you feel we have violated your rights by contacting us. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

### YOUR CHOICES

- For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
- In these cases, you have both the right and choice to tell us to:
  Share information with your family, close friends, or others involved in your care
  Share information in a disaster relief situation
  Contact you for fundraising efforts
- If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases of marketing or sale of information, we never share your information unless you give us written permission
- In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

*NOTICE OF PRIVACY PRACTICES CONTINUED…*

**OUR USES AND DISCLOSURES**

- How do we typically use or share your health information? We typically use or share your health information in the following ways.
- Treat you- We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- Bill for your services- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.
- How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
- For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html
- Help with public health and safety issues- We can share health information about you for certain situations such as preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; and, preventing or reducing a serious threat to anyone's health or safety.
- Do research- We can use or share your information for health research.
- Comply with the law- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests- We can share health information about you with organ procurement organizations.
- Work with a medical examiner or funeral director- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
- Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you for workers' compensation claims, for law enforcement purposes, or with a law enforcement official. We can also use or share health information about you with health oversight agencies for activities authorized by law for special government functions such as military, national security, and presidential protective services.
- Respond to lawsuits and legal actions- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**OUR RESPONSIBILITIES**

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

*Changes to the Terms of This Notice- We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. Effective April 8, 2019

Signature of Patient: _____ Date: _____

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# OFFICE POLICIES

*Please be advised of the policies for this office regarding any chiropractic or massage services.*

## Appointment Policy

We are so pleased that you have chosen Elite Movement Chiropractic Clinic for your health care needs! To best serve you, we have provided specific pre-scheduled appoint times for your adjustments. Because we respect your busy schedule, these times are held for you so we can do our best to make sure your visits are thorough, efficient, and provide the best care possible. If you cannot make an appointment, we ask that you please call to reschedule. Our office utilizes an alert system to send texts and emails to remind you of your upcoming appointment. If you do not wish to participate in this service please inform our office to opt out, or reply "STOP" on your device to unsubscribe.

## Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, (within 120 days) you may be held responsible. Your insurance policy is a contract between you and your insurance company, the doctor is not involved. We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. We will collect the co-payment at the time of service. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company. If you have insurance coverage with a plan that we do not accept or are not in network with, you will be responsible for services rendered due at time of service. Unless either you or your health coverage carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience we accept all major credit cards. All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. For all services provided by our physician(s) in our office, we will bill your health insurance. Any balance due is your responsibility. For all services rendered to minor patients, we will hold the parent/guardian accompanying the minor responsible for expenses incurred.

## Massage Policy

**Cancellation-** A 24-hour notice is required for cancellation of an appointment. We reserve the right to charge a **$30** cancellation fee (emergency circumstances will be taken into consideration). **Payment is due before your next appointment.** We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

**Tardiness-** Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment. If you are late, the fee for the full duration of the appointment will still be charged.

**Sickness-** Massage/Bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

**Financial Responsibility-** Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

*By signing below you acknowledge that you have read and agree to the terms of the office policies stated above.*

Print: _____ Signature:_____ Date:_____

# INFORMED CONSENT FOR CARE

I hereby request, and consent, to the performance of chiropractic manipulation, adjustments and other chiropractic procedures- including various modes of physical therapy and physical medicine procedures on me (*or on the patient named below for whom I am legally responsible) by Dr. Kuhlman and/or other licensed doctors of chiropractic or providers who now, or in the future, treat me while employed by, working/associated with/serving as back-up for *Elite Movement Chiropractic Clinic*.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel, the nature and purpose of chiropractic manipulations, adjustments, massage and other procedures. I understand that results are not guaranteed.

I understand, and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to be able to anticipate and explain all possible risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon facts known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Printed Patient Name: _____

Signature of Patient: _____ Date: _____

*__*The following is to be completed by the patient's representative, if necessary, e.g., if patient is a minor or physically or otherwise legally incapacitated.*__

*Printed Name of Patient Representative:* _____

*Signature of Patient's Representative*: _____

Relationship to Patient: _____ Date: _____

Witnessed: _____Date