MONROE THERAPEUTIC MASSAGE

MEDICAL MASSAGE

Please Print

Last Name _____ Hm Phone _____

First Name _____ M.I. _____ Wk Phone _____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip _____ Email Address _____

Occupation/Activities _____ Date of Birth ____/____/_____ Age ____ M ____ F ____

Injury Treatment? Yes _____ No _____ Date of Injury _____ Auto _____ Work _____ Other _____

Primary Insurance _____ Name of Insured _____

Address of Insured (if different than above) _____ City _____ State ___ Zip _____

Date of Birth of Insured (if different than above) _____ Relationship to Insured _____

Insurance Policy # _____ Group # _____

Secondary Insurance _____ Name of Insured _____

Address of Insured (if different than above) _____ City _____ State ___ Zip _____

Date of Birth of Insured (if different than above) _____ Relationship to Insured _____

Insurance Policy # _____ Group # _____

Auto Insurance (if PIP) _____ Claim # _____

Adjustor's Name _____ Phone _____

Workman's Comp or L & I _____ Claim # _____

Adjustor's Name _____ Phone _____

Please read and initial each line below:

___ I have contacted my health insurance company and have _____ visits per calendar year.

___ My deductible is _____. My co-pay or co-insurance is _____.

___ I will not hold Monroe Therapeutic Massage responsible for not knowing my insurance benefits and agree it is also my responsibility for tracking my massages so they do not exceed insurance maximums.

___ It is my responsibility to notify my therapist of any changes in my condition prior to treatment.

___ I understand my therapist does not diagnosis illness or disease.

___ I agree to the release of my information for medical and/or insurance for billing purposes.

___ I have been given or offered our privacy policy or HIPAA brochure.

___ We reserve the right to change our terms and conditions at any time.

___ I agree to cancel my appointments **24 hours in advance or be charged $35.00 for 20-50min, or $70 for 90-110min.**

___ I am fully responsible for all health care bills for services rendered and payment is not contingent on settlements, judgments, or insurance payments. Unpaid balances are due 30 days from statement or invoice date. Interest of 1.5% or $1.00 minimum per month will be charged until balance is paid. Rebilling fees may be added. Each returned check will be charged $25.00 plus bank fees. If applicable, court, attorney and collection agency fees may be charged up to 50%.

___ I acknowledge the above information is accurate and agree to notify MTM of any changes.

Patient/Guardian Signature _____ Date _____

Client Name _____

HEALTH HISTORY

Mark any condition that applies to you now or in the past. Please use '**C**' for current, '**P**' for past

____ Allergy to Nut Oils	____ Contagious Conditions	____ Low Back Pain
____ Arthritis	____ Decreased Sensation / Numb	____ Low Blood Pressure
____ Artificial Joint	____ Diabetes	____ Muscle Sprain / Strain
____ Blood Clots	____ Fibromyalgia	____ Osteoporosis
____ Bruise Easily	____ Headaches / Migraines	____ Pregnant
____ Bursitis	____ Heart Attack / Stroke	____ Skin Infections
____ Cancer / Tumor	____ High Blood Pressure	____ Varicose Veins
____ Contact Lens	____ Hypo or Hyperglycemia	____ Other Conditions _____

Other relevant health history _____

Occupation/Activities _____

Accidents, Injuries or Surgeries:

Less than 5 years ago _____

More than 5 years ago _____

Are you currently receiving medical or chiropractic care? Yes ____ No ____

If yes, please explain _____

Are you taking any medications (prescription & over-the-counter)? Yes ____ No ____

If yes, please explain _____

Habits	Heavy	Moderate	Light	None
Tobacco	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Exercise	_____	_____	_____	_____

What type of exercise? _____ How often? _____

Have you received massage before? Yes ____ No ____

What depth of work do you prefer? *(Please Circle)* Light / Medium / Deep / Very Deep

Why are you here today for massage? _____

INFORMATION AND SUGGESTIONS

- Prior to your massage, please remove contact lenses and all jewelry; pull long hair back with a clip or band.
- Massage is generally given while you are unclothed, however, you may wear undergarments or a swimsuit.
- During your massage you will be covered with a sheet. Only the area being worked on may be exposed.
- Your therapist is highly trained. You may ask your therapist questions before, during or after your massage.
- If the pressure is too intense or too light, please inform your therapist immediately.
- After your massage, your therapist may show you exercises or stretches to do at home.

Thank You