New Massage Member Intake Form

Date_____

Name: _____ _____
(First) (Last) (MI) (Name called by)

Name of legal guardian (if under 18 years old)_____

Date of birth:_____/_____/_____ Age:_____ _____Male _____Female

_____Single _____Married _____Divorced _____Widowed Spouse's Name:_____

# of Children_____ Names:_____

Address:_____ Occupation:_____

Home phone:_____ Cell phone_____Work phone:_____

Email:_____

EMERGENCY CONTACT:

Name:_____ Relationship:_____

Phone number:_____ _____Home _____Cell

How did you hear about us?_____

Have you recently been in an auto accident?_____

We offer a variety of services at Left Hand Chiropractic Center to address your body and mind in a holistic manner. please check any services which you are interested in learning more about.

__ Chiropractic __ Nasal Specific Adjustment __ ALCAT Allergy Testing

__ Massage Therapy __ Nutrition for arthritis/cold & flu/pain relief

Patient Condition

What is your major symptom/problem?_____

When did your symptoms begin?_____

Have you had this problem before? _____Yes _____No

Is your condition progressively getting worse? _____Yes _____No

Is this problem _____Constant _____Coming & Going

How does it feel? _____Burning _____Sharp _____Shooting _____Dull _____Aching

_____Stiff ____Tingling _____Throbbing _____Swollen _____Other_____

Circle below the severity of your pain on a scale of 0 - 10

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe pain)

Health History

List all medications you are taking_____

Vitamins/Herbs/Minerals_____

Females: Are you pregnant? _____Yes _____No If yes, how many months?_____

Circle any of the following conditions you have/have had:

Aids/ HIV	Asthma	Diabetes	Heart Disease	Irregular Cycle
Allergies	Bladder Problems	Digestion Problems	Hemorrhoids	Kidney Problems
Anxiety/ Depression	Cancer	Ear Ringing	Herniated Disc	Low Back Pain
Arm/ Shoulder Pain	Fatigue	Epilepsy	High Blood Pressure	Neck Pain
Arthritis	Headaches	Insomnia	Prostate Problems	Poor Circulation
Sinus Infection	Thyroid Problems	TMJ Problems	Vertigo/ Dizziness	Shingles
Osteoporosis	Sciatica	Stroke	Deafness	

Stressors:

___Alcohol Drinks/week_____

___Coffee/caffeine Drinks/day_____

___Smoking Packs/day_____

___High stress level Reason_____

Exercise:

___None

___Light

___Moderate

___ Heavy

Have you had any:	**Date**	**Description**
_____Auto accidents	_____	_____
____Surgeries	_____	_____
____Broken bones	_____	_____
____Falls/Head Injuries	_____	_____

Authorizations and Consent

Please initial each of the following:

_____ I understand I will be receiving a therapeutic, non-sexual massage and draping will be used during the session to ensure privacy and comfort. It is my responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivities or if I feel any discomfort during my session , such as inappropriate pressure.

_____ I understand and voluntarily accept any risks of which I have been advised associated with massage and hereby release my massage therapist(s) and Left Hand Chiropractic Center from all liability or any injury, including, without limitation, personal, bodily or mental injury or damage resulting from my failure to disclose any pre-existing condition, limitation or specific sensitivities, or my failure to inform my therapist of any discomfort during my session.

_____ Therapists have signed a non-compete agreement with Left Hand Chiropractic Center. Please honor this agreement by not arranging appointments with your therapist outside of Left Hand Chiropractic Center's practice.

_____ I have been offered a copy of Left Hand Chiropractic Center's HIPAA privacy act and I may obtain one for my personal use at any time.

Date_____

Financial Policy

Our goal is to make your visit with us as smooth and efficient as possible. Ashley, our office manager, will assist you with any questions you may have regarding your insurance billing or payment requirements.

Self-Pay Patients

We require 100% of the fee be paid at time of the visit to qualify for our Time of Service discount. We prefer payments of either cash or check, although we will accept major credit cards. We offer treatment packages which expire one year from the date of purchase. If you choose to terminate treatment, the cost of any unused visits will not be refunded.

Flex Plans/Medical Savings Accounts

Please inform us if you have a medical savings account or a "flex spending plan". We will be happy to provide you with a statement of your charges for reimbursement.

Personal Injury or Automobile Accidents

We require verification of all automobile insurance and billing information (i.e. claim number, policy number, billing address, etc.) before your first appointment.

There are four payment options available to our PI patients:

Pay cash for your care and we will submit reports whenever necessary.
We will bill and accept assignment from the Med Pay portion of your automobile insurance.
We will accept a Letter of Protection or Doctor's Lien from an attorney. Account balances of 90 days past the release date of treatment will incur a 1.5% monthly charge.
We will bill your standard health insurance plan and you will be responsible for all copays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement of your claim up to 6 (six) months after your care is completed. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

Cancelation Policy

We require 24 hours notice for all cancelations. If you call with less than 24 hours notice, or don't call at all, you will be billed a $30.00 fee for your missed appointment. This fee will be billed directly to you and will not be billed through any insurance. If you have purchased a treatment package and miss a scheduled appointment, one treatment will be deducted from your package.

I have read and understand this financial policy. I realize that I am responsible for all charges incurred by me at Left Hand Chiropractic Center. I agree to the above terms and authorize Left hand Chiropractic Center to collect from me payment if it is not received within ninety (90) days after my time of service.

Patient or Guardian's Signature_____