# Massage Therapy Intake Form

Name:______________________________ Date of Birth:____________

Primary phone number: (_____)__________Referred by:________________

Have you had a professional massage before?________ How often?______________

How do you exercise?____________________ How often? ____________

Occupation:__________________ Who is your chiropractor?__________

How do you relieve stress?______________________________

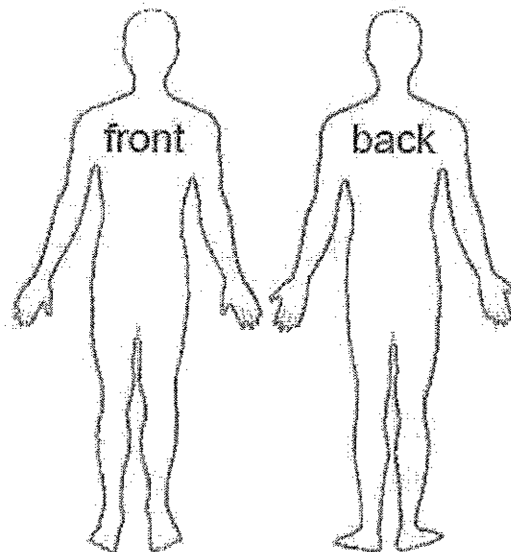
| What do you want me to work on specifically today? |
|---|
| Describe any surgeries in the last 2 years: |
| Describe any accidents in the last 2 years: |
| List all conditions monitored by a Health Care Provider: |
| List any medications you took today: |

Please **check** all current conditions:

| | | | | | |
|---|---|---|---|---|---|
| Headaches | | Scoliosis | | Poor circulation | |
| Sleep Problems | | Broken bones | | Thyroid dysfunction | |
| Fatigue | | Spinal/disc problems | | Sciatica | |
| Cold symptoms in last 48 hrs | | Muscle spasms/cramps | | Depression | |
| Sinus Problems | | TMJ (jaw) pain | | Blood Clots | |
| Allergies | | Tendonitis/bursitis | | Stroke | |
| Arthritis | | Varicose veins | | Heart disease | |
| Osteoporosis | | Stiff/painful joints | | High/low blood pressure | |
| Neck, shoulder or arm pain or numbness | | Currently pregnant | | Low back, hip or leg pain or numbness | |
| Asthma | | | | Malignant cancer or tumors | |
| Diabetes | | | | Benign cancer or tumors | |
| Describe any other condition(s): | | | | | |

# Massage Informed Consent Form

I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist prescribes neither medical treatment nor pharmaceuticals nor performs any spinal manipulations.
It has been made clear to me that this massage is not a subsitute for medical examinations and/or diagnosis and that it is to recommended that I see a physician for any physical ailments I might have.
Because a massage therapist must be aware of existing physical conditions I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.
I am indicating to my massage therapist those areas that I do not want included in my massage by circling the areas on the figures below.




Patient Signature____________________________
Printed Name___________________________
Date_______

*Cassis Dermatology & Aesthetics Center*

## PATIENT INFORMATION

**PLEASE PRINT**

GENDER (please circle) Male Female

PATIENT ______________________________
FIRST MIDDLE LAST

ADDRESS ______________________________
STREET PO BOXES MUST INCLUDE STREET ADDRESS CITY STATE ZIP COUNTY

BIRTHDATE ____/____/________

HOME PHONE _______/______-________

MARITAL STATUS S M D W O

WORK PHONE ______/______-________ EXT ________

EMAIL ADDRESS ______________________________

CELL PHONE ______/______-________

BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell (Please circle one)

☐ CHECK BOX TO RECEIVE EMAILS ABOUT COSMETIC PROMOTIONS AND SPECIALS

## PRIMARY INSURANCE INFORMATION

**PLEASE PROVIDE COPY OF INSURANCE CARD**

GUARANTOR ______________________________
FIRST MIDDLE LAST

ADDRESS ______________________________
STREET CITY STATE ZIP COUNTY

EMPLOYER / SCHOOL ______________________________
NAME & ADDRESS

BIRTHDATE ______/______/________

BEST NUMBER BTWN 9AM & 4PM (Please circle One) Home Work Cell _____/________-__________

RELATIONSHIP TO PATIENT ______________________

## SECONDARY INSURANCE INFORMATION

**PLEASE PROVIDE COPY OF INSURANCE CARD**

GUARANTOR ______________________________
FIRST MIDDLE LAST

ADDRESS ______________________________
STREET CITY STATE ZIP COUNTY

EMPLOYER / SCHOOL ______________________________
NAME & ADDRESS

BIRTHDATE ______/______/________

BEST NUMBER BTWN 9AM & 4PM (Please circle One) Home Work Cell _____/________-__________

RELATIONSHIP TO PATIENT ______________________

## EMERGENCY CONTACT INFORMATION

1) NAME ______________________________ RELATIONSHIP TO PATIENT ______________

HOME PHONE ______/______-________ CELL PHONE ______/______-________

WORK PHONE ______/______-________ ext______ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

2) NAME ______________________________ RELATIONSHIP TO PATIENT ______________

HOME PHONE ______/______-________ CELL PHONE ______/______-________

WORK PHONE ______/______-________ ext______ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

# Dermatology Medical History

Referred by: ____________

Patient: ______________________ Age: ________ Today's Date: ___/___/___

Reason for today's visit: ______________________

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1 ______________________ 2 ______________________

Have you ever had dental anesthesia (Novocaine)? ❑ YES ❑ NO Any bad reaction? ❑ YES ❑ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds , vitamins, and herbals):

1 ____________ 3 ____________ 5 ____________
2 ____________ 4 ____________ 6 ____________

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

| **Lungs:** | **YES** | **NO** |
|---|---|---|
| Bronchitis | ❑ | ❑ |
| Emphysema | ❑ | ❑ |
| Asthma | ❑ | ❑ |
| Chronic Cough | ❑ | ❑ |
| Morning Cough | ❑ | ❑ |
| Shortness of Breath | ❑ | ❑ |
| Wheezing | ❑ | ❑ |

| **Cardiovascular:** | **YES** | **NO** |
|---|---|---|
| High Blood Pressure | ❑ | ❑ |
| Chest Pain | ❑ | ❑ |
| Heart Attack | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ |
| Irregular Heartbeat | ❑ | ❑ |
| Phlebitis | ❑ | ❑ |
| Inflammation of vein | ❑ | ❑ |
| Blood clots | ❑ | ❑ |
| **Pacemaker** | ❑ | ❑ |

| **Other Systemic:** | **YES** | **NO** |
|---|---|---|
| Diabetes | ❑ | ❑ |
| Excessive thirst/hunger | ❑ | ❑ |
| Amputation | ❑ | ❑ |
| Thyroid | ❑ | ❑ |
| Kidney | ❑ | ❑ |
| Dialysis | ❑ | ❑ |
| Bladder | ❑ | ❑ |
| Frequency/burning | ❑ | ❑ |
| Gastrointestinal | | |
| Stomach absorptive disorder | ❑ | ❑ |
| Nausea, vomiting, diarrhea when taking antibiotics | ❑ | ❑ |
| Yeast infection when taking antibiotics | ❑ | ❑ |
| Arthritis/Joint Deformity | ❑ | ❑ |
| Arthralgia | ❑ | ❑ |
| Limited motion | ❑ | ❑ |
| **Artificial joint** | ❑ | ❑ |
| Convulsions, Epilepsy or Seizures | ❑ | ❑ |
| Fainting | ❑ | ❑ |

List any other diseases or conditions: ______________________

List surgical procedures you have had in the last 6 months: ______________________

**Skin:**
- Have you ever had skin cancer? ❑ YES ❑ NO
- Has anyone in your family had skin cancer? ❑ YES ❑ NO If yes, TYPE: ____________
- Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, ____________
- Do you have problems with healing ❑ YES ❑ NO
- Do you develop keloids (scars) after surgery ❑ YES ❑ NO
- Do you bleed easily? ❑ YES ❑ NO
- Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment ❑ Bandages ❑ Topical Neosporin ❑ Other ____________

**Social History:**

Do you drink alcohol? ❑ YES ❑ NO If YES ________ drinks per day

Do you use IV drugs? ❑ YES ❑ NO If YES, what? ____________ How often? ____________

Do you smoke? ❑ YES ❑ NO If YES, how much: ____________

Have you had or have you been exposed to HIV (AIDS) ? ❑ YES ❑ NO HEPATITIS? If YES, TYPE: A B C

Please answer the following questions:

**(Women) Are you pregnant?** ❑ YES ❑ NO Due Date: ___/___/___

What is your occupation? ____________ Hobbies? ____________

Completed by: ❑ Patient ❑ Medical Assistant ________ Initials

____________ Signed by Patient ___/___/___ Date

____________ Reviewed by ___/___/___ Date

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*Cassis Dermatology & Aesthetics Center*

## INSURANCE AND BILLING AUTHORIZATION

I understand I am personally responsible to Cassis Dermatology & Aesthetics Center (The Practice) for any charges incurred for services performed regardless of insurance coverage. I accept full FINANCIAL RESPONSIBILITY for the patient's account in accordance with the regular rates and terms of The Practice's policy

I understand most health insurance carriers require The Practice to file a claim for my services, but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. These amounts may include co-payments, deductibles, and fees not covered by my health insurance. IF MY INSURANCE CARRIER REQUIRES A REFERRAL FOR MY OFFICE VISIT, I UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN THIS AND PRESENT THIS REFERRAL AT THE TIME OF MY VISIT (IF NOT BEFORE). Failure to obtain a referral, if required, does not release me from my responsibility to The Practice. SERVICES PROVIDED WITHOUT A REFERRAL, IF A REFERAL IS REQUIRED, REMAIN MY RESPONSIBILITY.

I understand that if I am not covered under a current insurance policy or if I do not present a current insurance card at the time of service, that I will be responsible for payment in full at the time services are rendered.

Most aesthetic services are not covered by health insurance Biopsy and removal of skin lesions may not be covered by my health insurance I am responsible for payment of any aesthetic services or treatments or any medical conditions not covered by my insurance.

I hereby authorize The Practice to submit a claim to my Insurance Carrier or it's intermediaries related to services rendered by any physician or medical provider employed by Cassis Dermatology & Aesthetics Center, and direct my insurance carrier or it's intermediaries to issue payment directly to The Practice and/or provider who accepts assignment.

Signature ______________________ Date ______________________

## NO SHOW FOR APPOINTMENTS AND COLLECTION FEES

I understand when The Practice provides an appointment time; I remain responsible for payment for services. If I fail to notify The Practice with 24-hour notice, I remain responsible for payment for my appointment. Failure to notify The Practice may result in a $25 no show fee. I understand my health insurance will not cover this fee, and I will remain personally responsible for payment of this fee. Repeated failure to show for appointments may result in my dismissal from The Practice.

If Cassis Dermatology & Aesthetics Center refers my account to a collection agency, I agree to a pay all fees, collection fees and legal fees, associated with my delinquent account I understand I will be responsible for any collection fees, including any legal expenses incurred in settling my delinquent account. I understand a delinquent account may be reason for termination from The Practice.

Signature ______________________ Date ______________________

## CONSENT FOR CARE AND TREATMENT OF DEPENDENT

PERMISSION FOR TREATMENT is hereby grant to any physician or medical provider employed by The Practice to render such medical and surgical treatment as deemed necessary for

______________________
Dependent's Name

Signature of Parent or Guardian ______________________ Relationship to Patient ______________________

## NOTICE OF PRIVACY PRACTICES

I acknowledge Cassis Dermatology & Aesthetics Center (the Practice) has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature ______________________ Date ______________________

Printed Name of Patient or Personal Representative (If different than patient only) ______________________ Relationship to Patient ______________________

## CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby consent to Cassis Dermatology & Aesthetics Center using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

________________________________ ______________________
Signature Date

________________________________ ______________________
Printed Name (if different than patient only) Relationship to Patient

## SPECIFIC INFORMATION RELEASE (if applicable)

I specifically authorize release of the following information for the purposes of treatment, payment, and health care operations:
**(Initial any you agree to release)**

_____ Chemical Dependency/Substance Abuse

_____ Sexually Transmitted Diseases

________________________________ ______________________
Signature Date

________________________________ ______________________
Printed Name (if different than patient only) Relationship to Patient

# FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality treatment of each and every patient. Please understand that payment for your bill is considered part of your treatment The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

**All patients must complete our Patient Registration process prior to seeing the physician.**

WE ACCEPT CASH, CHECKS, VISA & MASTERCARD.
In the event of a returned check, for any the following reasons: non-sufficient funds, stop payment or closed account, a fee of $30 00 will be charged to your account.

## INSURANCE CARD

We will not bill your insurance company unless you provide a current insurance card.

## PARTICIPATING PROVIDER (CONTRACTED)

We accept assignment of insurance benefits on many insurance plans. During the Patient Registration process you will be told whether or not we accept assignment of your insurance benefits. We will file all charges to your insurance company. Because we are a participating provider with your insurance carrier, you be responsible to pay any **co-pay** amounts **each visit**. You will also be responsible for any deductible/coinsurance amounts, as stated in your policy, and you will receive a statement in the mail, from our office, for these amounts If you participate in a High Deductible Insurance Plan, you will be asked to pay at the time of service. We will file the claim on your behalf with your carrier. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be **due in full at the time of service**

## NON-PARTICIPATING PROVIDER (NON-CONTRACTED)

Because we are not contracted with your insurance carrier, you will be responsible to pay your total charges. We will file all charges to your insurance company. You will be responsible for any charges not covered by your insurance carrier, as stated in your policy We will allow 45 days to receive payment from the insurance carrier; if not received, the entire balance will be billed to you. You will receive a statement in the mail from our office for these amounts Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be **due in full at the time of service**. We will ***not*** follow-up with your insurance carrier on any unpaid claim. It is your responsibility to work directly with your insurance carrier on any disputed or unpaid claims.

## RATES

Our practice is committed to providing the best treatment for our patients at a rate considered usual and customary for our area.

## MINOR PATIENTS

Minor patients must be accompanied by a parent or legal guardian each visit. The parent/legal guardian accompanying the minor to the first visit will be considered guarantor on the account; therefore, accepting full financial responsibility for all services rendered on the minor's behalf and charged to their account.

Thank you for understanding our Financial Policy Please let us know if you have any questions or concerns

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X ______________________________
Patient Name (Please Print)

X ______________________________ Date ______________
Signature of Patient or Responsible Party

X ______________________________ Date ______________
Signature of Co-Responsible Party