

# BODY SAGE

Orthopedic Massage & Chiropractic Wellness  
9430 SW Coral Street, Suite 203 Tigard, OR 97223  
Tel: (503) 644-1418 Fax: 503 644-1422

## PATIENT REGISTRATION FORM

Patient's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_ Mr.  Mrs.  Miss  Ms.   
\_\_\_\_\_ is this your legal name? Yes  No

If *not*, what is your legal name? \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed  Separated

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: Male  Female

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How did you hear about Body Sage: Dr.  Insurance  Family  Friend  Web  Yellow Pages   
Social Media  Mailer  Other  \_\_\_\_\_

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: Kaiser  Aetna  Cigna  Ash  CHP  Other  \_\_\_\_\_

Subscribers Name: \_\_\_\_\_ Subscribers Birthdate: \_\_\_/\_\_\_/\_\_\_

Group No. \_\_\_\_\_ Policy Number: \_\_\_\_\_

Deductible: Yes  No  Deductible Amount: \$ \_\_\_\_\_ has this amount been met? Yes  No

Amount remaining until deductible is satisfied: \$ \_\_\_\_\_ Co-pay: Yes  No  Amount \$ or % \_\_\_\_\_

Physician Referral Required? Yes  No  Treating Physician: \_\_\_\_\_

Patient's relationship to subscriber: Self  Spouse  Child  other

Secondary Insurance (if applicable): Kaiser  Aetna  Cigna  Ash  CHP  Other

Subscribers Name: \_\_\_\_\_ Subscribers Birthdate: \_\_\_/\_\_\_/\_\_\_

Group No. \_\_\_\_\_ Policy Number: \_\_\_\_\_

## IN CASE OF EMERGENCY

Name of relative or local friend: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the treating physician or therapist. I understand that I am financially responsible for any balance. I also authorize Body Sage Orthopedic Massage & Chiropractic Wellness and my insurance company to release any information required to process my claims.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

Body Sage Employee: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

### Please take a moment to carefully read the following information

- If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral form from your primary care provider may be required prior to service being provided.
- I understand that massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension.
- If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.
- I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified medical specialist for any medical or physical ailment that I am aware of.
- Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly.
- I agree to keep the therapist updates as to any changes in my medical profile and understand that there shall be no liability on the therapists part should I neglect to do so.
- I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

### Information and Suggestions for the Client

- Prior to your massage, remove any loose jewelry. Pull long hair back with a clip or tie.
- Take off only as much clothing as you are comfortable. As a rule, massage is given while you are unclothed for better access to muscles. We provide a top sheet and / or towel. Modesty and comfort levels vary from person to person. You may choose to wear undergarments or a swim suit or nothing at all. This is YOUR massage and you should feel as comfortable as possible.
- During your massage, you may want to notify the therapist of any discomfort. This can be from the pressure (deeper or lighter) or to point out painful or ticklish areas of your body.
- Feel free to ask your therapist any questions about their procedures and techniques. Your therapist is a highly trained professional and will be happy to make you feel well informed and comfortable.

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## MEDICAL INTAKE FORM

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Telephone: \_\_\_\_\_ Occupation: \_\_\_\_\_

### **Please answer the following:**

1. Have you ever had a professional massage before? Yes  No
2. How often do you receive massage therapy and/or when was your last massage?  
\_\_\_\_\_
3. What is the main reason for your visit today?  
\_\_\_\_\_  
\_\_\_\_\_
4. Are you currently under the care of a health practitioner? Yes  No   
If yes, what for? \_\_\_\_\_  
May, I have permission to contact? Yes  No   
Physician's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_
5. Have you had any accidents in the last five years? Yes  No  If yes, please explain:  
\_\_\_\_\_
6. Are you taking any medications? Yes  No  If yes, what for?  
\_\_\_\_\_
7. Is there an area of the body which you are experiencing pain, stiffness, tension or other discomfort? Yes  No  If yes, please explain:  
\_\_\_\_\_

### **Please check** yes or no to the following questions, and explain if necessary:

- Yes  No  Are you feeling well today? \_\_\_\_\_
- Yes  No  Do you have any skin disorders? \_\_\_\_\_
- Yes  No  Allergies? \_\_\_\_\_
- Yes  No  Any recent injuries or surgeries? \_\_\_\_\_

### Have you ever been diagnosed with ANY of the following conditions?

- Yes  No  Arthritis
- Yes  No  High/Low Blood Pressure
- Yes  No  Heart Disease If yes, explain: \_\_\_\_\_
- Yes  No  Diabetes If yes, when? \_\_\_\_\_
- Yes  No  Osteoporosis If yes, when? \_\_\_\_\_
- Yes  No  Cancer If yes, what type: \_\_\_\_\_
- Yes  No  Spinal Conditions If yes, explain: \_\_\_\_\_
- Yes  No  Currently pregnant? If yes, when is your due date: \_\_\_\_\_
- Yes  No  Other medical conditions? \_\_\_\_\_

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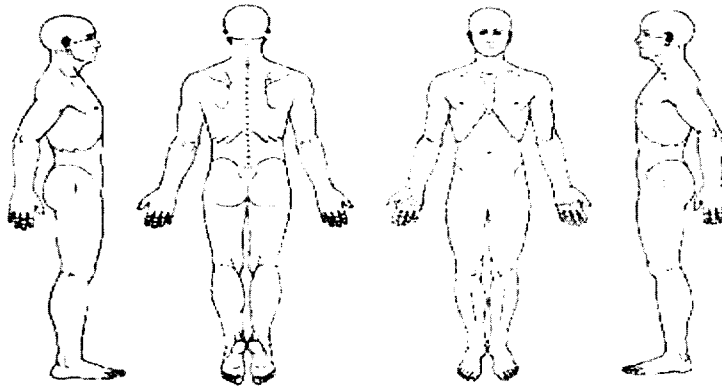
8. Using the chart, please mark an "X" on areas of discomfort, tingling, aching, spasms, stiffness, numbness, dysfunction, and areas of concentration to work on and describe below:

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**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/20\_\_\_\_

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## FINANCIAL POLICY

Thank you for choosing **Body Sage Orthopedic Massage & Chiropractic Wellness** as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered we have been advised to develop this payment policy. Please read it, ask any questions you have, and sign in the space provided. A copy will be furnished upon your request.

1. **Insurance:** We participate in most insurance plans. We can verify and check on your insurance benefits for you prior to receiving care, but it is your responsibility to know your insurance benefits. However, insurance companies will never allow that a quote of coverage is a guarantee of benefits. If you have a copay, coinsurance or unmet deductible, you will be responsible for payment at time of service. We will require a deposit of \$80.00 until your insurance is verified. We will bill your insurance for services rendered in the office. After the receipt of Explanation of Benefits (EOB) from your insurance carrier, we can apply the deposit to your co-pays or refund the balance. **Patient Initials** \_\_\_\_\_
2. **Time of Service Discount (TOS):** We offer a time of service discount to our patients that have high deductibles. No health insurance or just prefer to pay cash. Payment is due in full at the time services are rendered. Please note that we will not bill your insurance or go back and bill at a later date once a TOS discount is given.
3. **Non-Covered Services:** Please be aware that some and perhaps all of the services you receive may not be covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of visit.
4. **Proof of Insurance:** All patients must complete our patient information forms before seeing a therapist or the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner you may be responsible for the balance of a claim.
5. **Claim Submission:** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly, but it is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, and we are not a party to that contract.
6. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 90 days, the balance will automatically be billed to you.
7. **Personal Injury/Workers' Compensation:** Most Personal Injury and Workers' Compensation claims are covered 100%. However, it is your responsibility to provide our office with the documentation necessary to prove a valid claim, as well as the name(s) of any claims adjuster/attorney, etc. handling the case, claim numbers, and mailing address to send bills. Failure to provide the documentation needed will result in the immediate conversion of your case to cash, and all payment will be due on receipt. **Patient Initials** \_\_\_\_\_

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8. **Non-payment:** If your account is over 90 days past due you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted, unless otherwise negotiated with Body Sage Massage. Please be aware that if a balance remains unpaid we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
9. **Missed Appointments:** Our policy is to charge \$50.00 for missed appointments not canceled within a 24 hour period to your appointment time. This also includes same day re-scheduled appointments. These charges will be your responsibility and billed directly to you.

Please help us to serve you better by keeping your regularly scheduled appointment. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy for Body Sage Massage Orthopedic Massage & Chiropractic Wellness and agree to abide by its guidelines. I also understand that I am ultimately financially responsible for all services not paid by insurance or other third party. Should there be a balance due at the end of my treatment plan, I will receive an invoice and pay it promptly, or contact the office to make payment arrangements.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## **Health Information Privacy and Accountability Act (HIPAA)**

In accordance with the Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding this center's use of your Protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by Body Sage Orthopedic Massage & Chiropractic Wellness. Your health information will be used and disclosed to provide treatment or services. The doctor who is involved in your care and who prescribed medical massage will disclose your health information to us, and we will disclose health information about you to that doctor.

For example, a doctor treating you may know of conditions you have that require special care, avoidance of certain therapies, or expectations for healing that your medical massage therapist needs to know about, while your medical massage therapist will share all findings with the prescribing doctor. We will use and disclose health information about the treatment and services you receive from us so that we can bill and receive payment. We will also tell your insurance company about the treatment you are going to receive to determine whether your plan will cover it.

Information about your treatment and services may also be disclosed to your attorney if such attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment for medical massage. Although your health record is the physical property of Body Sage Orthopedic Massage & Chiropractic Wellness, you have the right to inspect and, upon written request, obtain a copy (for a fee) of your health information, which usually includes prescriptions and medical and billing records.

If you believe the health information we have about you is incorrect or incomplete, and this office still maintains your information, you may submit a written request to amend your records. Our disclosure of your health information is limited to this office, the physician who prescribed physical medicine, your insurance company, your attorney, you and anyone you authorized in writing to receive information from us. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient. The minor patient's health information will be disclosed to the parents or guardian.

If you believe your privacy rights have been violated, you may file a written complaint to:  
**Office of Civil Rights; U.S. Department of Health & Human Services** at 200 Independence Avenue S.W. Room 509f, HHH Building, Washington D.C. 20201. You will not be penalized for filing a complaint.

By signing this form, you hereby acknowledge that Body Sage Orthopedic Massage & Chiropractic Wellness may release your Protected Health Information to carry out payment processing and treatment operations. I have read and understood the Notice of Privacy Practices of Body Sage Orthopedic Massage & Chiropractic Wellness.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_