BODY SAGE THERAPIES

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

WELCOME

The providers and staff of **BODY SAGE THERAPIES** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to the therapies, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

PATIENT INFORMATION

First Name: _____ **MI**: ____ **Last Name:** _____

Mr. □ Mrs. □ Miss □ Ms. □ Date of Birth: ____/____/_____ Age: _____ Sex: Male □ Female □

Mailing Address: _____

City: _____ State: _____Zip Code: _____

Telephone: _____ Email: _____

Occupation: _____ Employer: _____

Name of Parent of Minor Patient (If applicable) _____

How did you hear about Body Sage: Provider □ Insurance □ Family □ Friend □ Web □ Yellow Pages□
Social Media □ Mailer □ other: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance: _____

Patient's relationship to subscriber: Self □ Spouse □ Child □ other □ _____

Subscribers Name: _____ Subscribers Birthdate: ____/____/_____

HR#/Sub ID: _____ Effective Date: _____ through _____

Physician Referral Required? Yes □ No □ Treating Physician: _____

Deductible: Yes □ No □ Deductible Amount: $ _____ has this amount been met? Yes □ No □ $ _____

Coverage for: Acupuncture □ Co-pay: $_____ Chiropractic □ Co-pay: $ _____ Massage □ Co-pay: $ _____

Limitations: □ 12 visits per calendar year □ $_____ max combined for services Double Insurance: Yes □ No □

IN CASE OF EMERGENCY

Name of relative or local friend: _____

Relationship to patient: _____ Phone Number: _____

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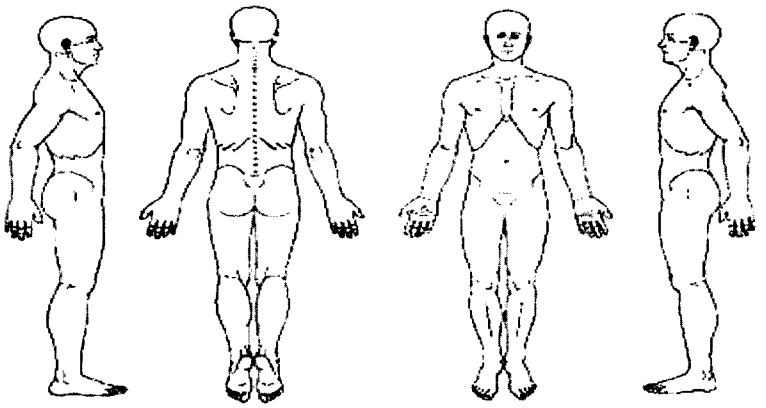
8. Using the chart, please mark an "**X**" on areas of discomfort, tingling, aching, spasms, stiffness, numbness, dysfunction, and areas of concentration to work on and describe below:

_____

_____

_____

_____



Patient Signature: _____ **Date:** _____/_____/20_____

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FINANCIAL POLICY

Thank you for choosing **Body Sage Therapies** 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. **Patient Initials** _____
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 Therapies**. 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 Therapies** 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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CONSENT TO AUTHORIZE DISCLOSURE OF INFORMATION (HIPAA)

Patient's Name: _____

Patient's DOB: ____/____/____ **Patient's Phone Number** _____

I hereby authorize the use and disclosure of individually-identifiable health information related to me as described below:

Specific description of information to be used or disclosed:

A. **Schedule re-schedule, confirm or cancel appointments**
B. **All account financial information, to include all third party information (MVA, WC)**
C. **Making payments, insurance inquiry, account balances or collection inquiry**
D. **Requesting medical records and billing invoices**
E. **Retrieving prescriptions, imaging orders, medication samples or specific written**
F. **doctors' orders**

I authorize the following person to receive my information:
(Please write the name of the person)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

I understand I may revoke this authorization at any time by notifying **Body Sage Therapies** in writing. If I choose to do so, my revocation will not affect any action taken by **Body Sage Therapies** before receiving my revocation.

This authorization will expire on: 12/31/2020 (unless revoked sooner by patient/parent representative)

Patient's Signature: _____ **DATE:** ____/____/20____

PATIENT REPRESENTATIVE: (If applicable)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____

DRIVER'S LICENSE # _____ **ISSUING STATE:** _____

Patient's Signature: _____ **DATE:** ____/____/20____