

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 N/A

(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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Natasha El Massih, MAcOM, LAc
9430 SW Coral Street, Suite 203 Tigard, OR 97223
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ACUPUNCTURE MEDICAL HISTORY FORM

Full Name: _____

Date of Birth _____ / _____ / _____ Age: _____ Optional: Height _____ Weight _____ lbs.

Have you been treated by Acupuncture or Oriental medicine treatment(s) before? Yes No if yes, how often do you receive acupuncture: _____

MAIN COMPLAINT AND PRESENT MEDICAL HISTORY

Main problem you would like us to help you with:

How long ago did this problem begin? _____

Have you been given a diagnosis for this problem? Yes No if so, please describe:

Are you currently receiving treatment for your problem? Yes No if so, please describe:

PAST MEDICAL HISTORY

Have you had any serious illness in the past? Yes No if so, please describe:

Have you had any surgeries? Yes No if so, please describe:

Have you had any accidents or injuries in the past 5 years? Yes No if so, please describe:

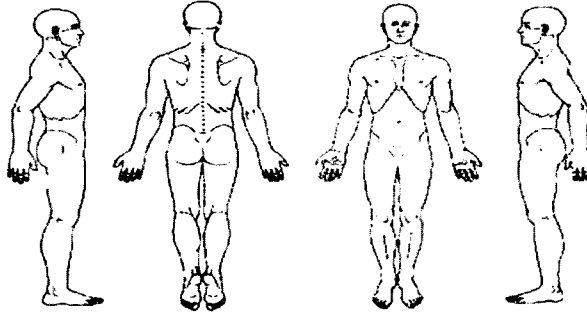
Are you taking medications, herbs, vitamins, supplements? Yes No if so, please describe:

Is there an area of the body which you are experiencing pain, stiffness, tension, or other discomfort?
Yes No if so, please describe:

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Please mark an "X" on the diagram any areas of pain or injury.



FAMILY MEDICAL HISTORY (GENERAL HEALTH)

Mother's Side

Father's Side

Sibling's N/A

PERSONAL HISTORY

Hobbies & Recreational Habits: _____

Do you have a regular exercise program? Yes No if so, please describe:

Please describe smoking or alcohol intake: N/A

Are there any other concerns you would like to discuss?

CONSENT TO ACUPUNCTURE TREATMENT

I, the undersigned, understand acupuncture treatment to involve the use of needles, acupressure, moxibustion, cupping, and electrical stimulation etc. The risks, although limited, include: puncturing organs in the abdomen or chest cavities. Acupuncture may affect people on all levels: physical, emotional, mental and spiritual, because it works with the whole body to create balance. The duration of treatment varies from person to person depending on the specific illness and their constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or a series of treatments.

Patient Signature: _____ Date: _____

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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____