BODY SAGE THERAPIES

7973 SW Cirrus Dr Beaverton, OR 97008
Tel: (503) 644-1418 Fax: 503 644-1422

MVA/WC ACCIDENT INTAKE

PATIENT INFORMATION

Patient LEGAL Name: _____Date: _____/_____/20_____

DOB: _____/_____/_____ 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 _____

CLAIM INFORMATION

Has the accident been reported to the insurance company? □ Yes □No

Insurer: _____ Claim #: _____

Claim Adjuster: _____ Tel: _____

E-mail: _____ Fax: _____

ACCIDENT/INJURY INFORMATION

Nature of Accident:

1. D/Injury:_____/_____/20_____ Time of Day: _____AM/PM Weather: _____
2. Where you: □ Driver □ Passenger □ Front Seat □Back Seat □Middle Back Seat
3. Number of people in your vehicle? _____ Other vehicle? _____
4. What direction where you headed? □North □East □South □West
   On (name of street and/or hwy) _____
5. What direction was the other vehicle headed? □North □East □South □West
6. Were you struck from: □Behind □Front □ Left Side □ Right Side _____
7. Were you knocked unconscious? □Yes □ No If yes, for how long? _____
8. Were police notified? □Yes □ No
9. In your own words, please describe accident:

   _____
   _____
   _____

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10. Did you have any physical complaints BEFORE THE ACCIDENT? □ Yes □No
    If yes, please describe in detail:

    _____

    _____

11. Please descibe how you felt:
    - DURING the accident: _____
    - IMMEDIATELY AFTER the accident:_____
    - LATER THAT DAY: _____
    - THE NEXT DAY:_____
12. What are your PRESENT complaints and symptoms?

    _____

    _____
13. Do you have any congenitial (from birth) factors which relate to this problem? □Yes □No
    If yes, please describe: _____
14. Do you have any previous illnesses which relate to this case? □Yes □No
    If yes, please describe: _____
15. Where were you taken after the accident? _____
16. Have you ever been treated by another doctor since the accident? □Yes □No
    If yes, please provide the doctor's name and address:

    _____

CHECK SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:

□Headache(s)	□Irritability	□Numbness in Toes
□Face Flushed	□Feet Cold	□Neck Pain
□Chest Pain	□Shortness of Breath	□Buzzing in Ears
□Hands Cold	□Neck Stiff	□Dizziness
□Fatigue	□Loss of Balance	□Stomach Upset
□Sleeping Problems	□Head seems Too Heavy	□Depression
□Constipation	□Back Pain	□Pins & Needles in Arms
□Lights Bother Eyes	□Loss of Smell	□Cold Sweats
□Nervousness	□Pins & Needles in Legs	□ Loss of Memory
□Loss of Taste	□Fever	□Tension
□Numbness in Fingers	□Ears Ring	□Fainting

Symptoms Other Than Above:

_____

17. When did your symptoms begin?: _____/_____/20_____ or _____
18. Did you have any of these symptoms before the accident? □ Yes □ No
19. Since the injury occurred, are your symptoms: □ Same □Worse □ Improving
20. Have you lost time from work as a result of this accident? ? □ Yes □No
    If yes, please complete the following:
    - Last Day Worked: _____
    - Are you being compensated for time lost from work? □ Yes □No

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21. Do you notice any activity restrictions as a result from this injury? □ Yes □No
    If yes, please describe, in detail:

    _____

    _____

22. Have you ever been involved in an accident before? ? □ Yes □No
    If yes, please describe, include date(s) and type(s) of accidents, as well as injuries received:

    _____

    _____

    _____

23. Has an attorney been retained? □ Yes □No
    If yes, Please provide your attoney's name, telephone, and address:

    _____

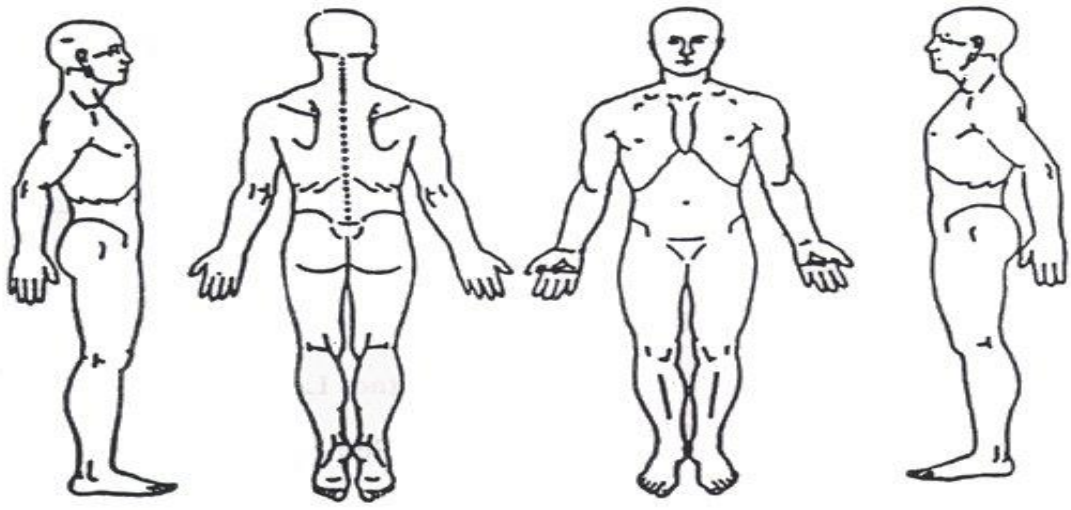
24. Other pertinent information: (medications, operations, pregnancy, etc.)

    _____

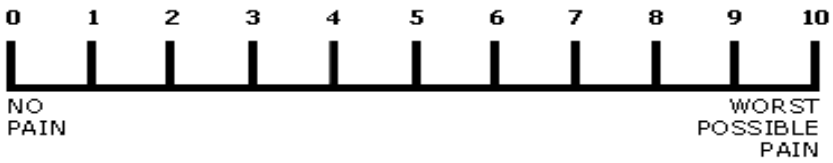
    _____

    _____

25. Please mark an **X** on the areas affected as a result of your injury:



26. Please indicate your current pain level on a scale of 0-10, with 10 being the worst possible pain: _____



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IN CASE OF EMERGENCY

Name of relative or local friend: _____

Relationship to patient: _____ Phone Number: _____

INFORMED CONSENT

PLEASE READ CAREFULLY

- The above information is true to the best of my knowledge. I authorize my insurance company to pay Body Sage Therapies directly to the treating provider.
- I understand that I am financially responsible for any balance. I also authorize Body Sage Therapies and my insurance company to release any information required to process my claims.
- I understand that the massage given to me by_____is for the purpose of (stress reduction, pain reduction, relief from muscle tension, increasing circulation, or specific reasons stated here).
- I understand that the massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals, nor are spinal manipulations part of massage therapy.
- I understand that massage therapy is not a substitute for medical care and that it is recommended that I work with my primary caregiver for any condition I may have.
- I have stated all my known physical conditions and medications, and I will keep the massage therapist updated on any changes.

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** _____

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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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 Therapies**. 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 Therapies**, 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 Therapies 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 Therapies.**

Signature: _____ **Date**: _____