mvc/mva intake form

Fox Massage LLC 1829 NE Alberta St 97211 & 1920 NW Lovejoy St 97209
Kathryn Clippard LMT#19681 503.333.2425 kathryn@foxmassage.com

Name: _____ Date of Birth: _____
Last, First, MI MM/DD/YYYY

Address: _____
Street, Apartment (if applicable), City, State, Zip

Phone Number: _____ E-mail: _____

Primary Care Physician: _____

Clinic Name & Phone Number: _____

Auto Insurance Company Name : _____

Policy #_____Claim#: _____Date of Incident: _____

Claim Adjustor: _____

Phone and Fax Numbers: _____

Primary Insured: _____

Address: _____
Street, Apartment (if applicable), City, State, Zip - or write "same as above"

Primary Insured's DOB: _____ Relationship to Primary Insured: _____
MM/DD/YYYY

Health Insurance Company Name: _____

Policy ID #: _____

Emergency Contact: _____
Name, Phone Number, Relationship

Attorney: _____
Name, Office Name, Phone Number

Referring Medical Provider: _____

Clinic Name & Phone Number: _____

Permission to consult (circle one): Yes No

Brief Description of Incident and Resulting Injuries:

_____

_____

_____

_____

Are you currently taking any medications? Please list: _____

_____

Do you have specific likes and/or dislikes regarding massage? _____

_____

What are your primary goals for your massage treatment(s)? _____

_____

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Please indicate if you have or have had any of the following conditions:

____ Arthritis
____ Spinal Condition
____ Lymph Node Removal
____ High Blood Pressure
____ Heart Condition
____ Blood Clots
____ Kidney Problems
____ HIV or AIDS
____ Cancer
____ Diabetes
____ Osteoporosis
____ Varicose Veins
____ Chronic Pain; if so, where?_____
____ MRSA
____ Irritable Bowel or Digestive Issues
____ Hepatitis or Liver Issues
____ Skin Disorder (rash, infection, etc.)
____Allergies/sensitivities: _____

Any other medical condition(s) not listed?
_____

Client Agreement:
It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for therapeutic massage treatment. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. ***Initial*** ____

In consideration of my fellow patients and massage practitioner, I understand that a minimum of 24 hours notice is required to change or cancel an appointment. I further acknowledge that I will be held responsible for the full cost of the session should I cancel, miss, or reschedule within the 24 hour time period, unless I send someone in my place. I understand my insurance company **will not pay** for the missed appointment. ***Initial*** ____

Release of Medical Records:
I authorize the release of medical records or other health information, including intake forms, chart notes, reports, correspondence, billing statements and other written information to my attorneys, healthcare providers, and insurance case managers, for purpose of processing my claims. ***Initial*** ____

Assignment of Benefits:
I am responsible for all charges for all services provided. In the event that my insurance company denies payment, or makes partial payment, I am responsible for any balances due. I authorize and direct payments of medical benefits to Emily Harwood, LMT DBA Earth & Sky Massage Therapy for services billed. ***Initial*** ____

By my signature, I verify that all information provided is true and correct to the best of my knowledge. Furthermore, I agree to abide by these policies.

Signature: _____ Date: _____