ENERGIZE CHIROPRACTIC + WELLNESS

Massage Intake Form

Last Name ______________________________ Hm Phone ______________________________

First Name ____________________ M.I. ______ Wk Phone______________________________

Mailing Address ___________________________ Cell Phone ______________________________

City _________________ State _____ Zip ______ Email Address __________________________

Occupation________________ Date of Birth ___/___/___ Age ____ ❍ Male ❍ Female Marital Status: __________

Injury Treatment? ❍ Yes ❍ No Date of Injury ___/___/___ ❍ Auto ❍ Work ❍ Other ______________________

How did you learn about us?____

Why are you here today for massage? ____

Have you received professional massage before? ❍ Yes ❍ No

If yes, what depth of work did you received? ❍ Light ❍ Medium ❍ Deep ❍ Very Deep

Level of conversation you prefer during your massage: ❍ I love to chat ❍ I lead the conversation ❍ I prefer silence

Health History

Are you currently receiving medical or chiropractic care? ❍ Yes ❍ No

If yes, please explain ____

List current medications and purpose: ____

____

Mark any condition that applies to you now or in the past. Please use 'C' for current, 'P' for past

___ Allergy to Nut Oils
___ Arthritis
___ Artificial Joint
___ Back Pain
___ Blood Clots
___ Bruise Easily
___ Bursitis
___ Cancer / Tumor
___ Contagious Conditions
___ Decreased Sensation / Numb
___ Diabetes
___ Fibromyalgia
___ Headaches / Migraines
___ Heart Attack / Stroke
___ High Blood Pressure
___ Low Blood Pressure
___ Menstrual Pain
___ Neck Pain
___ Thrombosis / Embolism
___ Osteoporosis
___ Pregnant: # wks _______
___ Sciatica
___ Skin Infections
___ Varicose Veins

Other relevant health history: ____

Accidents, Injuries, or Surgeries:

Less than 5 years ago: ____

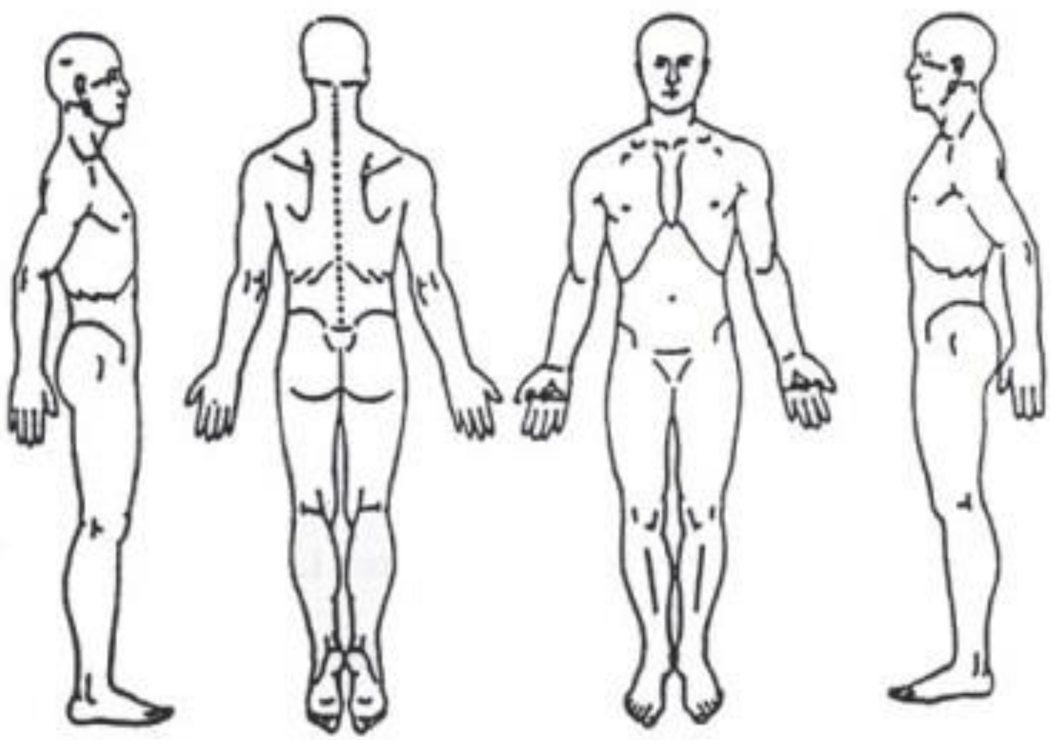
More than 5 years ago: ____

Do you exercise? ❍ Yes ❍ No Type? ______________________________ How often? _______________

Please complete other side →

<u>Circle</u> any areas you would like the massage therapist to ***focus*** on during the massage.

<u>Put an "X"</u> on any areas you would like the therapist to ***avoid***.



Any other questions or concerns? ____

____

<u>Please READ and INITIAL:</u>

____ Payment is due at the time of service. We accept cash, checks, Visa, MasterCard and American Express.

____ There is a $15.00 charge for returned checks.

____ If the appointment is missed or cancelled <u>without</u> 24-hour notice, **your <u>card on file *will* be charged</u> a $30 fee**.
You may contact us easily by phone, text, or email to inquire about making changes to your scheduled time.

____ Massage therapists do not diagnose illness or disease, or prescribe treatments.

____ All information provided is complete and accurate; I will notify Energize Chiropractic + Wellness of any changes.
Any changes in my physical condition will be told to my treating LMP prior to my treatment.

____ We reserve the right to change the terms and conditions at any time.

Patient/Guardian Signature ________________________________ **Date** ________________

AUTHORIZATION

It is the practice of this office to provide chiropractic care in an "open adjusting" environment. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. The environment is used for ongoing care and is NOT the environment used for taking patient histories, performing examinations, or presenting reports of findings. These procedures are completed in a private, confidential setting.

We are requesting this authorization of you due to various interpretations under federal law with respect to what is known as an "incidental disclosures" of health information. It is our view that the kinds of matters related in an "open adjusting" environment are incidental matters. In the event you or someone else would not agree with us, we are providing this disclosure.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality healthcare and health information. If you choose not to be adjusted in an open adjusting environment, other arrangements will be made for you.

It is our desire for our staff to use your name, address and/or telephone number for the purpose of contacting you to advise you about health related meetings, workshops, and products.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care, a health oriented newsletter, or about the status of your account. If you would like to receive this information at an address other than your home, or, if you would like the information in a different form, please advise us in writing as to your preferences.

The use of this information is intended to make your experience with our office more efficient, productive, and to further enhance your access to quality healthcare.

Your decision will have no adverse effect on our care from Energize Chiropractic + Wellness or on your relationship with our staff.

This notice is effective as of April 14, 2015. This notice, and any alterations or amendments hereto will expire 15 years after the date upon which the record was created.

Your signature indicates your authorization of this activity.

Name (printed) **Signature** **Date**

You may revoke this authorization at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.

Energize Chiropractic + Wellness
Privacy Policy

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
In the course of your care as a patient at Energize Chiropractic + Wellness (ECW), we may use or disclose personal and health related information about you in the following ways:
• Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
• Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if they are/ or may be responsible for the payment of your services).
• Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or other health related information that may be of interest to you.

You have the right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:
• If we are providing health care services to you based on the orders of another health care provider.
• If we provide health care services to you in an emergency.
• If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
• If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
• If we are ordered by the courts or another appropriate agency

You have the right to receive an accounting of any such disclosures made by this office.
Any use or disclosure of your of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.
Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.
We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.
We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.
We reserve the right to alter or amend to the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information our files.
If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to: Dr. Jeremy Meadows D.C.

If you would like further information about our privacy policies and practices please contact: Dr. Jeremy Meadows D.C.
You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open-adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same adjusting room at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and this is NOT the environment used for taking patient histories, providing examinations or presenting report of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment, other arrangements will be made for you.

This notice is effective as of April 10 2015. This notice, and any alterations or amendments made hereto, will expire 15 years after the date upon which the record was created

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Description of the authority to act on behalf of the patient