Union Center For Healing LLC Confidential

MASSAGE INTAKE FORM

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Is it ok to contact you via email? Yes: _____ No:_____ Email: _____

Home Phone: _____ Work: _____ Cell: _____

Gender: _____ Marital Status: _____ Occupation: _____

Referred By: _____ Emergency contact & phone#_____

Are you currently/within the last year been under the care of your Primary Care Dr.?_____ Primary Care Physician: _____ What conditions? _____

Is this your first Massage? _____ What are your goals for today's Massage? _____

Describe your main concerns (Symptoms, onset, diagnoses, duration, etc.)

_____
_____
_____
_____
_____
_____

What makes your condition better? (rest, movement, heat, cold, fresh air, eating, crying, etc.)_____
_____
_____

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, damp days etc.) _____
_____
_____

Please indicate where your symptoms are occurring & indicate any pain, tenderness, burning, numbness, tingling, stiffness, swelling, bruising, open wounds, scars, etc.

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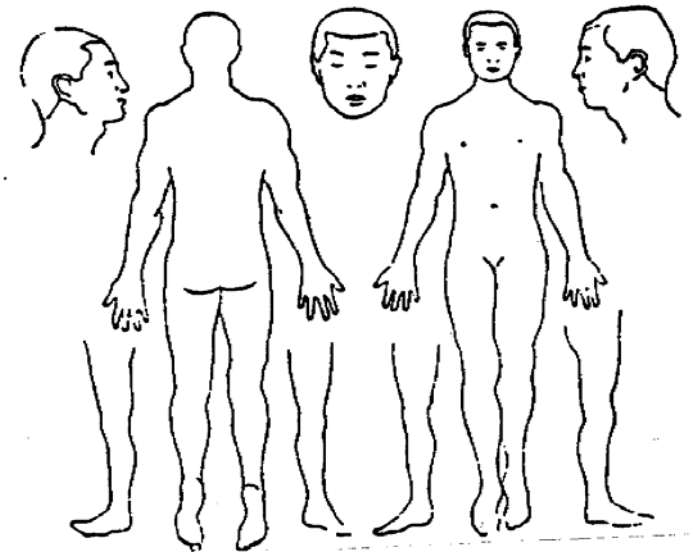

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

Personal History Please check any conditions you have now or have had in the past.

____ High/Low Blood Pressure
____ Low Back Pain
____ Allergy to Nut Oils
____ Osteoporosis
____ Diabetes
____ Pregnant
____ Varicose Veins
____ Bursitis
____ Skin Infections
____ Hypo or /Conditions
____ Low Blood Pressure
____ Bleeding conditions
____ Heart Attack / Stroke
____ Arthritis
____ Headaches
____ Blood Clots
____ Seizure/Epilepsy
____ Ulcer

TREATMENT CONSENT FORM

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health. Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to hold harmless and release from any liability employees of Union Center For Healing Integral PLLC for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive.

I also understand and agree that if I make any illicit or sexually suggestive remarks or if I exhibit any sexual misconduct, I will be liable for payment for the "full" scheduled session, the appointment will end immediately, and I will not be allowed to receive massage at this establishment in the future.

The following are contraindications for massage (or should be consulted by your physician first):
Acute infectious diseases, Skin rashes, Atherosclerosis, Embolism or thrombus (blood clotting), Some cancers, Fever, Heart attack (OK after complete recovery), Herpes, Massage is ok when there are no visible lesions, High risk pregnancy, Skin infections, Skin lesions/open wounds/sores, Thrombophlebitis (blood clot), Diabetes with vascular dysfunction, Bursitis, Burns, Artificial blood vessels, Tendon & Muscle Ruptures. If you have been diagnosed or are experiencing any of the above**, please indicate on the Intake Form and inform the practitioner.**

I will notify the therapist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points could induce miscarriage.

Printed Name_____Signature _____ Date_____

(Of patient, parent or representative)

Insurance and Payment Information-FOR YOU TO KEEP, PLEASE READ

We want you to experience your time here with minimal effort. The following information will help you become familiar with the insurance process, including billing, copays, contracted rates and statements from Union Center For Healing and Nightingale Billing Service.

If you have any questions about your statements please contact Nightingale Billing at alan@nightingalebilling.com or call 206-508-0330.

YOUR PART:

- Confirm that your insurance covers Acupuncture or Massage and you obtain any referral or prescription needed prior to your first appointment.
- Be sure your plan covers the conditions for which you would like to be seen; most plans only cover certain conditions.
- Finally, keep track of the number of visits allowed on your plan.
- Please know the contract is between you and your insurance carrier and you are fully responsible for any amount that they do not pay. Our office does not guarantee that your insurance will pay.

MASSAGE: Prescriptions are needed for massage prior to the first date of service. Insurance will not cover visits without a prescription. **The following information is required on the prescription:** Start and end dates, diagnoses, number of visits, provider or clinic name, and your provider's name. Please note that most plans only cover specific pain related conditions. Find out what is covered under your plan to be sure the condition you want treated is covered.

COPAYS: If you have a copay (indicated on your card) you can pay it at the time of your appointment or every 2-4 appointments. We accept Cash, Check and Credit Cards. Any copays not collected at the time of service will be billed.

BILLING: We use a third party biller, Nightingale Billing, to process claims and payments. Claims are sent to your insurance company every week and are usually processed by the insurance company within 9-30 days. Since we are contracted with your plan, we agree to be paid the contracted rate, which is a set amount. Your financial obligation is the copay, or co-insurance (a percentage), or deductible. If you are paying towards your deductible, you are only responsible for the contracted rate. **Codes billed:** There are only a few codes that we use for acupuncture. On your first visit you will see a first office visit code (99201-99203) and the standard two codes used for a typical acupuncture treatment , 97810/97811 or 97813/97814. On some return visits you may see 99212 which indicates a new condition or further evaluation. Massage is coded 97124 or 97140.

STATEMENTS: Statements are mailed monthly every 4 weeks for balances due. These balances include deductibles, copays, co-insurances, or any balances unpaid by the insurance. The statements will only include balances due once the insurance has been processed.

PAYMENTS: You may pay your balance with cash, check or credit card. You can mail it in or bring it in with you to your next appointment. Coming soon you will be able to pay with your paypal account through our website. If you wish to pay through paypal now, please email us.

RECEIPTS: Nightingale can provide you with a summary of your visits for you FSA plan.

LATE CANCELLATION/MISSED APPOINTMENT AGREEMENT

Please provide 24 hours advance notice of any changes or cancellations.

Appointments that are missed/rescheduled/cancelled with less than 24 hours notice will be billed $40.

Signature: _____ Date:_____

INSURANCE INFORMATION

Coverage is not guaranteed and needs to be verified with your health plan. Although acupuncture is generally a covered service, it is only covered for certain conditions. Most plans require a prescription for massage.

Name _____ Date of birth _____
Employer _____ Single ____ Married ____

PRIMARY INSURANCE: Insurance Name: _____
Subscriber ID #(**include letters**) _____ Group # _____
Relationship to insured: Self _____ Spouse/DP _____ Child _____ Other_____

PLEASE FILL OUT INFORMATION BELOW IF YOU DID NOT CHECK SELF:
Name on plan if not self _____ Date of Birth _____
Address (if other than yours) _____
Employer _____ Phone # _____

If your primary insurance does not cover acupuncture or massage but you have secondary insurance that does. We will be glad to provide you with a superbill for you to submit for reimbursement from your insurance company.

MOTOR VEHICLE (PIP) OR L & I:
Claim #_____ Company Name _____
Billing Address: _____
Contact Name _____ Phone number_____
Date of Injury _____ Name of insured _____
Attorney Name, Address and Phone _____
_____

PLEASE READ AND SIGN:
In the event that my insurance coverage expires or denies payment, I understand that I am personally, fully responsible for all fees incurred. I agree to release any medical information my insurance company, adjustor, or the attorney involved in my case may need in order to process payment. I assign some benefits to be paid to the above named provider.

Signature _____ Date _____

HIPAA Privacy Practices Acknowledgement Form

Due to new HIPAA compliance statutes, we as a healthcare provider are required to provide you with a Notice of Privacy Practices that describes your rights as a patient and must document that every patient or client has read and received it. The form is found on our website and is available at our center for you to read and take home with you.

By Signing below, I acknowledge the receipt of the Notice of Privacy Practices at Union Center For Healing Integral, PLLC.

Printed Name_____Signature _____ Date_____
(Of patient, parent or representative)

Communication Consent

We are required (UCFH and the individual provider) to have your consent to communicate via Email, Fullslate (online scheduling) and Text. At this time the emails, text and Fullslate are not encrypted. We are able to communicate with you by each of these forms but need your consent to do so. If you have sensitive health care information you wish to share through email, contact your provider first so we can send an encrypted message.

I consent to communicate by email, text, and Fullslate: Yes _____ No _____