VSC Wellness Center
Chiropractic • Acupuncture • Massage Therapy

# MASSAGE THERAPY

Today's Date _____

Last Name: _____ First name _____

Age _____ Sex: M F

Address _____

City _____St_____ Zip_____

Home Phone _____ Cell Phone _____

Date of birth _____

Occupation _____Employer_____

Employer Address_____

Work # _____

Emergency Contact: _____ Phone_____

***How did you hear about our office: Drive-by, Phone book, Newspaper, Internet, Patient or other person (please list so we may thank them)*** _____

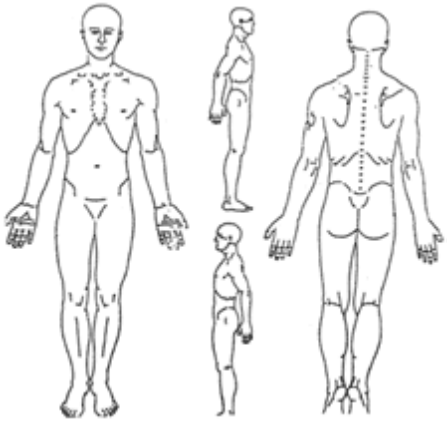
Have you had massage therapy in the past [ ] No [ ] Yes
Have you had chiropractic care in the past [ ] No [ ] Yes
If yes, what were you treated for? _____

Are any of the conditions you are seeking treatment for related to a motor vehicle accident or injury on the job?
[ ] No [ ] Yes, please
explain_____

**Type of massage you are looking for:**
[ ] Deep tissue [ ] Craniosacral therapy [ ] Trigger point therapy
[ ] Relaxation [ ] Active Release [ ] Other_____

**Check all that currently apply:**
[ ] Bruise easily [ ] allergies to scents [ ] allergies to lotions [ ] blood clots
[ ] poor circulation [ ] skin rash [ ] diabetes [ ] pregnant
[ ] asthma [ ] broken bones [ ] osteoporosis [ ] spasms/ cramps
[ ] arthritis [ ] spinal problems [ ] headaches [ ] sinus trouble

**Please mark your areas of pain on the figures below.**



**Is your pain:**
[ ] dull [ ] sharp [ ] stabbing [ ] achy [ ] numb
[ ] tingling [ ] throbbing [ ] tight

## List the conditions that bring you to this office

(Note if they are getting better or worse)

1_____

2_____

3_____

4_____

**What functions are you unable to perform or activities that induce pain upon performance?**

1_____

2_____

3_____

4_____

5_____

Have you had any other treatment for these problems? [ ] No [ ] Yes, please list:
_____

It is my choice to receive massage therapy, and I give consent to receive treatment. I understand that Massage Therapist DO NOT diagnose illness, disease or any other physical or mental disorders. Massage therapy is not a substitute for chiropractic/ medical examination and/or diagnosis. I affirm that I have stated all of my known medical conditions and shall take it upon myself to keep my Massage Therapist updated on my physical/mental health. I also agree there shall be no liability on the practitioner's part should I neglect to do so. I understand payment is due at the time of service. I understand that any fees incurred by the office to collect any debt are also my responsibility including but not limited to postage, attorney's fees, and court costs.

♦Signature _____Date _____

## ***Consent to Share Confidential Medical Information***

**TO BE VALID, ALL LINES WITH AN ASTERIK (*) ON THIS FORM, MUST BE FILLED OUT COMPLETELY, including what information you are giving us permission to share. Place N/A on lines not applicable to your care.**

*Patient's Legal Name: _____ *DOB_____

***I HEREBY AUTHORIZE VSC WELLNESS CENTER TO SHARE:**

☐ 1. Any of my medical information, including information about my medical diagnoses and imaging results
☐ 2. My appointment times, dates, and reasons for the visits and/ or billing issues
☐ 3. The following information (specify): _____

***WITH THE FOLLOWING PEOPLE:**

Full Name: _____ Relationship: _____

Authorized to share: 1 2 3 This authorization expires: Date: _____

Full Name: _____ Relationship: _____

Authorized to share: 1 2 3 This authorization expires: Date: _____

*I understand that my treatment, enrollment, or eligibility for benefits will not be conditioned on my signature ----------Initial_____

*I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law ---------- Initial_____

*I understand that I may cancel this consent at any time (by writing to VSC Wellness Center), but that canceling it will not affect any information that has already been released. I understand that I do not have to sign this form, and that I should only sign it if I want my provider or my clinic to share my information with someone. If no expiration date or event is specified, this authorization will expire one (1) year after the date it is signed.

*Signature: _____ Date: _____

*Relationship to minor patient (if parent or legal guardian) : _____
If you are not the minor patient's parent, you must give us proof of guardianship (for example, a court order or power of attorney)

Witness: _____ Date: _____

## ***Acknowledgement of Policies and Procedures / Please Read and Sign***

*Co-Pays are due at the time of service. Account balances must be below $150.00. ----------Initial_____

*It is required that you arrive 10 minutes before your scheduled muscle therapy appointment. If you are not here at that time your appointment may be given to another patient. ----------Initial_____

*We require a 24-hour notice to change or cancel appointment. A $25 fee for a 30 min appointment or a $30 fee for a 60 min appointment will be charged if you cancel or miss a muscle therapy appointment with less than 24-hour notice. No-Show/less than 24-hour notice more than 3 times will require prepayment at the time of scheduling for any future muscle therapy appointments. ----------Initial_____

*I have been given the opportunity to review the Financial Terms and Conditions ----------Initial_____

HIP & MEDICAID PATIENTS:

*If you miss three (3) scheduled muscle therapy appointments, you will not be able to schedule any muscle therapy appointments for a year. Any previously scheduled appointments will be cancelled after the third missed appointment----------Initial_____

## ***Acknowledgement of Privacy Policy***

*Certain treatments may be performed in a common therapy area and/or you may find yourself within public areas within the clinic, but please note private rooms are always available, upon request, for discussing your private health information---------- Initial_____

*This is to acknowledge that I have been given the opportunity to review VSC Wellness Center's Notice of Privacy Practices.
I acknowledge that I have read and understand the policies and procedures of VSC Wellness. I understand that I have the right to request a personal copy of this office's Notice of Privacy Practice.

*Sign _____ *Date _____