**MASSAGE CLIENT INFORMATION FORM**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW DID YOU HEAR ABOUT US?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY REASON FOR APPOINTMENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle your answer**: **Explanation**:

Have you had a massage before? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have skin problems or allergies? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you suffered an acute injury recently YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have varicose veins or blood clots? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have arthritis? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have heart problems? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have spinal problems? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise or participate in any sports? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you presently under emotional strain? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you under more stress than normal? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have blood pressure problems? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on blood thinning medications? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you seeing a chiropractor or therapist? YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else your therapist should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supplement list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Desired pressure: ◻ light ◻moderate ◻firm Current level of pain: Scale 1-10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Areas to avoid (i.e. feet, head, hands, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension/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 spinal manipulations. It has been made 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 ailment that might be progressive.

With this in mind, I agree to hold massage therapist and massage therapy harmless for any problems that might arise as a result of any massage therapy session.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZATION FOR CASE REVIEW

Here at **MANGI Chiropractic & Acupuncture, Inc.** we take a holistic approach to each patient’s health care. It is our desire that each patient receive an optimum health care evaluation. This means that it may be necessary to have another specialist, through consultation with the doctor, review your case for their opinion. This may be in the form of previous records from other providers or current findings in our office. Your signature below acts as a release to obtain those records. In this way, we can deliver high quality care to you, our patient.

**THE PURPOSE OF THIS OFFICE IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I am responsible for knowing my insurance coverage. The doctor’s office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor’s office will be credited to my account upon receipt. I, the undersigned, certify that in the event I (or my dependent) have insurance coverage I assign directly to

Dr. Andrea Mangi-Bassett/MANGI Chiropractic & Acupuncture, Inc., all insurance benefits. However, I clearly understand and agree that all services (from first/past treatment(s) to present) rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and/or treatment, any and all fees for services rendered me will be immediately due and payable and I agree that any credit card on file will be charged for the full amount due plus late fees if they apply. A delinquent account is subject to bear interest at the maximum legal rate and a set late fee ($35.00 per month). Should the account become delinquent and be referred to a collection agency or legal representative, I shall pay all reasonable associated expenses, including but not limited to court fees, attorney fees, collections/collection agency fees etc. A $35.00 rescheduling fee for missed appointments will be added to my account unless I have contacted the office at least 24 hours before my scheduled appointment.

***I hereby authorize the Doctor/Therapist to treat my condition as deemed appropriate. I also acknowledge that services provided are billed per each service i.e. spinal adjustment, extremity adjustment, traction table, electrical stimulation, x-rays; etc. are separate codes with separate dollar amounts and are billed to insurance according to their insurance codes. If certain therapies are not wanted after doctor deems them necessary for expedited recovery, it is patient’s responsibility to inform doctor of therapies that are unwanted.*** It is understood and agreed the amount paid to the Doctor/Therapist for diagnostic images, is for examination of images only and all negatives will remain the property of this office, being on file where they may be reviewed at any time while a patient with this office. The Doctor/Therapist will not be held responsible for any pre-existing medically diagnosed conditions, not for any medical diagnoses. This agreement does not expire.

Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MISSED APPOINTMENT FORM**

**I AGREE TO PAY $35.00 FOR MISSED APPOINTMENTS NOT CANCELLED IN 24 HOURS. WHILE WE UNDERSTAND THINGS TO HAPPEN, WE MUST BE RESPECTFUL TO OTHER PATIENTS WHO MIGHT NEED THAT APPOINTMENT TIME AND RESPECT OUR THERAPISTS/STAFFS TIME AS WELL. IF FEE IS NOT PAID, NO FURTHER APPOINTMENTS WILL BE ALLOWED TO BE SCHEDULED.**

**I AGREE TO HAVE MY CREDIT CARD HELD ON FILE AND FOR IT TO BE CHARGED FOR ANY AND ALL OUTSTANDING BALANCES.**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXPIRATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CVV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**