New MVA Client Intake

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Re-Member Massage
For Nanci Williams, LMT #14787

Name: _____ Date: _____

Address: _____ ODL: _____

City: _____ State_____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ Date Of Accident: _____

Date of Birth: _____ Employer/Occupation: _____

In case of emergency, please contact:

Name: _____ Phone: _____

Who Referred You : _____ Phone: _____

Accident Information: Date of Accident_____Time of Accident _____

Were you the □ Driver □ Front Passenger □ Rear Passenger □ Pedestrian

Please describe the accident in your own words: _____

_____

_____

Make and model of the vehicle you were in _____

Were you wearing a seatbelt? □ Yes □ No If so, what type? □ Shoulder □ Lap

Was the vehicle equipped with airbags? □ Yes □ No If yes, did they inflate properly? □ Yes □ No

Did your vehicle have a headrest? □ Yes □ No If yes, what position was it in? □ Low □ Mid □ High

Did your car impact another car? □ Yes □ No Did your car impact a structure? □ Yes □ No

Did any part of your body strike anything in the vehicle? □ No □ Yes _____

Was the impact from the □ Front □ Rear □ Left □ Right □ Other _____

At the time of impact where were you looking? _____

Were both hands on the steering wheel? □ Yes □ No If no, which one was on the wheel? □ L □ R

Was your foot on the brake? □ Yes □ No If yes, which foot was on the brake? □ L □ R

Were you □ Surprised by the impact □ Braced for the impact

What speed were you traveling? _____What speed was the other car traveling? _____

Driving conditions: □ Dry □ Wet □ Icy □ Other

OVER

Client Condition

Were you unconscious immediately after the accident? □ Yes □ No

Please describe how you felt immediately after the accident _____

_____

Treatment

Did you go to the hospital (urgent care)? □ Yes □ No / Were X-rays taken? □ Yes □ No /

MRI? □ Yes □ No

When did you go? □ Immediately after the accident □ The next day □ 2 days or more after

Diagnosis_____

Treatment received _____

Symptoms and/or Injuries

Have you been able to work since the injury? □ Yes □ No

Has this injury influenced your work performance? □ Yes □ No If yes, how?

_____

If you have had any of the following symptoms since your injury please check the appropriate box:

□ Aching	□ Difficulty eliminating	□ Fatigue	□ Radiating Sensation	□ Stress
□ Blurred vision	□ Discomfort	□ Headaches	□ Sharp pain	□ Swelling
□ Breathing difficulty	□ Disorientation	□ Irritability	□ Shooting pain	□ Tenderness
□ Burning sensation	□ Dizziness	□ Muscle Spasms	□ Sleep difficulty	□ Throbbing
□ Coughing	□ Dull pain	□ Nausea	□ Sneezing	□ Tightness
□ Cracking noises	□ Ear buzzing	□ Numbness	□ Soreness	□ Tingling
□ Cramping	□ Ear ringing	□ Popping sounds	□ Stiffness	□ Weakness
□ Difficulty arising				

Symptoms are in the:

□ Head	□ Jaw	□ Neck	□ Wrists	□ Hands
□ Hips	□ Thighs	□ Legs	□ Ankles	□ Feet
□ Chest	□ Shoulders	□ Buttocks	□ Abdomen	
Back:	□ Upper	□ Middle	□ Lower	

Symptoms are worsened by:

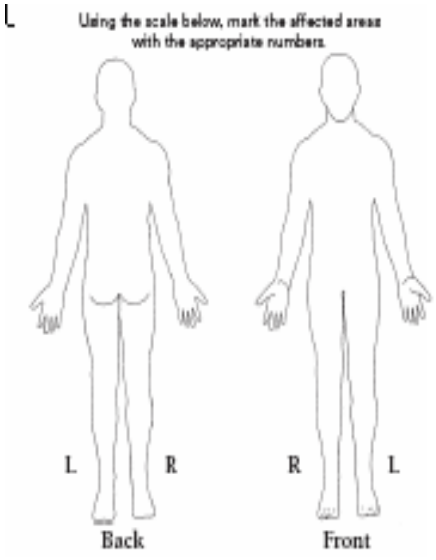
□ Driving	□ Exercise	□ Lifting	□ Bending
□ Cold	□ Work	□ Standing	□ Sitting
□ Twisting	□ Walking	□ Daily Activity	

□ Other _____

Symptoms are eased by:

□ Lying Down	□ Resting	□ Hot Packs	□ Cold Packs
□ Medication	□ Massage	□ Activity	

□ Other _____



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How to rate your symptoms on a pain scale of 1 to 10	
10 Your pain is intense, constant, greatly restricts your activities, and it is impossible to go more than 5 minutes without awareness of the pain. **9** Your pain is intense, constant, greatly restricts your activities, but you can forget about the pain for up to 15 minutes at a time. **8** The pain is significant, moderately intense at times, but not constant. Most activities are affected, and you think about it once or twice an hour. **7** The pain is significant at times, but never intense and not constant. Most activities are affected, and you think about it once or twice an hour. **6** The pain is moderate, yet too frequent to ignore. Some activities are affected. Hours can go by without being aware of the pain.	**5** The pain is moderate, yet too frequent to ignore. Almost no activities are affected. Hours can go by without being aware of the pain. **4** The pain is little more than a nuisance, and you go through your whole day frequently aware, but not really affected by it. **3** The pain is little more than a nuisance, your awareness of the pain may be absent for a whole day at a time, and you are never affected by it. **2** At its worst, the pain is best described as uncomfortable. Days can go by without being aware of it. **1** At its worst, the pain is best described as uncomfortable. Your symptoms do not recur more frequently than once a week.

Medical History

Please check Yes or No to the following questions, and explain in spaces provided:

YES NO

- □ □ Are you wearing any medical devices? □ Contacts, □ Dentures, □ Hearing Aid □ Other_____
- □ □ Do you suffer from any of the following?
  - Skin disorders: □ Rash, □ Yeast, □ Fungus, □ Psoriasis, □ Infection, □ Other_____
  - Allergies: □ Oils, □ Nuts, □ Skin care ingredients, □ Other _____
- □ □ Are you under the care of a physician for any reason? Please explain_____
- □ □ Are you taking any medications? If yes, when was your last dose?_____
- □ □ Any recent/current illnesses? □ Infectious, □ Viral, □ Bacterial, □ Other _____
- □ □ Have you ever been diagnosed with any of the following conditions?
  - □ Arthritis. Type and location(s) _____
  - □ High blood pressure, □ Low blood pressure, □ Aneurism, □ Embolism, □ Other_____
  - □ Heart Disease _____
  - □ Diabetes: □ Type I, □ Type II (Adult Onset), □ Other _____
  - □ Cancer. Type and location(s) _____
  - □ Spinal condition: □ Scoliosis, □ Osteoporosis, □ Other _____
  - □ Other medical condition(s)_____
  - Date(s) of diagnosis of any of the above conditions _____
- □ □ Have you ever had surgery? Affected area of the body_____Date/Year(s) _____
- □ □ Do you have any needs that require special attention? _____
- □ □ Do you have any questions before we get started? _____

Other:_____

_____

(For Women Only)

YES NO (Menstrual)

- ☐ ☐ Pain/Cramping
- ☐ ☐ Irregularity
- ☐ ☐ Other_____
- ☐ ☐ Are you now pregnant? What trimester? _____ Any problems?_____

General Understanding
I understand that Massage Therapy and other related health care services from me are not in any way to be used instead of or in place of consulting a Physician for diagnosis and treatment of any physical symptoms; but to be used in conjunction with, or on the advice, referral, or prescription of a Physician. By my signature, I verify that all information provided on the previous 3 pages is true and correct to the best of my knowledge. I promise to keep my health care providers updated on any changes in my health and residence.

_____ **Please initial.**

Payment Policy
If your insurance company does not pay for your massages, then you will be responsible for and billed at the therapeutic rate which does not include the 75% administration fee charged to your insurance company.

_____ **Please initial.**

Cancellation Policy
I understand that my scheduled appointments are reserved exclusively for me. I agree to call my therapist as soon as I know I cannot keep an appointment. All missed appointments and cancellations made after 24 hours preceding any scheduled appointment, will be billed at full price. I agree to be responsible for these charges, and payment will be made before the time of my next visit. If I miss three appointments without notice, my treatment will be terminated and I will pay full price for my missed appointments. I understand that this policy is in place to assist my Massage Therapist in providing the best possible care to me and all others who benefit from her services.

_____ **Please initial.**

I authorize my massage therapist to release any information in her possession requested by my insurance company for the purpose of processing claims. I understand that I will receive a therapeutic massage for the purpose of maintaining good health and physical condition. Even though massage can be profoundly relaxing and health promoting, once in a while, a few side effects may occur: bruising (usually from Trigger Point therapy), dizziness/light headedness, muscle soreness 24 – 48 hours after massage, stiffness (usually from dehydration), red patches (from Gua Sha/Graston Technique). I hereby give my **informed consent** to receive therapeutic massage from Nanci Williams, LMT #14787

_____ Date _____
Client (or Guardian's) Signature

Financial Policies and Notice of Privacy Practices

Re-Member Massage, LLC
Nanci Williams, L.M.T. #14787,
1675 SW Marlow Ave, Suite 307D, Portland OR 97225
503-939-9123 phone / 503-530-8174 fax

My goal is to provide the highest quality massage, bodywork and qigong experience to each client I see. The following credit and payment policies have been established to assist in achieving this goal. My office accepts Cash, Checks and Debit/Credit/HSA/FSA cards. There is a $35.00 fee for returned checks.

☐☐**PRIVATE PAY PATIENTS**: As I understand Re-Member Massage LLC does not take health insurance, I agree to accept full responsibility to provide payment at the time service is rendered, with applicable discounts applied. There is a separate "Package Discount" form available for me to sign on www.remembermassage.com website, which outlines further financial agreements and understandings.
_____ client initials

☐☐**MOTOR VEHICLE COLLISIONS:** It is Oregon State law that in order to have my services paid by my auto insurance company I must provide my provider with my insurance company information for billing. If I do not provide this information I agree to the terms

set forth under PRIVATE PAY PATIENTS. If my insurance company has not made a payment within 45 days I will assist this office in resolving my account issues. If I have retained an attorney and am expecting settlement, I am still fully responsible to pay for my sessions at the time of service, and arrange with my attorney to reimburse me directly. I also agree to the terms of net 30 days for any amounts not paid by my auto insurance company.
_____client initials

☐☐**TERMINATING PROVIDER/PATIENT RELATIONSHIP:** Both Nanci Williams, L.M.T. and I reserve the right to terminate the relationship/session at any point for any reason, including those supported by Oregon Law. Nanci Williams, L.M.T. has found usual causes for termination include three "no shows" or late cancellations for scheduled appointments, seriously delinquent balances or failure to pay amounts due, inappropriate behavior towards providers or staff, failure to follow requests to limit bodily/clothing stench from perfumes/chemicals/smoke of any kind to help maintain indoor air quality, failure to follow session plans or referral recommendations to ensure health and safety of the client. Fortunately, terminating a relationship is a rare occurrence.
_____client initials

I have read and understand the above policies for the practice of Nanci Williams, L.M.T. I have read and initialed the policies particular to my financial and insurance agreement with Re-Member Massage LLC. I accept these policies and agree to abide by the terms stated above. I have received a copy of my signed Financial Policies Agreement.
_____client initials

HIPAA PATIENT CONSENT FORM

I, _____ , consent to the use or disclosure of my protected health information by Nanci Williams, L.M.T., for the purpose of providing massage and bodywork to me, or to conduct the health care operations of Re-Member Massage, LLC. I understand that Nanci Williams, L.M.T., is not legally allowed to diagnose or treat diseases, but may be conditioned to request medical information by me upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or the health care operations of the practice. Nanci Williams, L.M.T., is not required to agree to the restrictions that I may request; however, if Nanci Williams, L.M.T., agrees to a restriction that I request, that restriction is binding. Nanci Williams, L.M.T., will only forward my health care information to people/business that I have allowed by filling out and signing "Release of Information Client Consent" form found on her website www.remembermassage.com.

"Protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information is information related to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe this information identifies me.

I understand that I have a right to review Nanci Williams, L.M.T., Notice of Privacy Practices prior to signing this document. Nanci Williams, L.M.T., Notice of Privacy Practices has been provided to me. The notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations of Re-Member Massage. The Notice of Privacy Practices also describes my rights and the duties of Nanci Williams, L.M.T., with respect to my protected health information. I have been given a chance to ask questions and they have been answered.

Re-Member Massage, LLC, reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by contacting the HIPAA representative at the office and requesting a revised copy be sent in the mail or by asking for one at the time of my time of my next appointment.

_____ (initial) Nanci Williams, L.M.T., reserves the right to leave a message (or text) on the client's home answering machine/recorder or private cell phone. As the client, I specifically consent to this right.

_____ (initial) Nanci Williams, L.M.T., reserves the right to leave an e-mail which may show up on the client's private cell phone. As the client, I specifically consent to this right.

_____(initial) I understand that if I, the client, refuse to sign this consent form, my health care information cannot be given to insurance companies, and consequently, I, the patient, will be responsible for the entire bill and will be billed accordingly.

_____
Signature Sign and PRINT of Client or Responsible Party and the Date