Re-Member Massage, LLC
5075 SW Griffith Dr., Suite 210 Beaverton OR 97005; PH: 503-939-9123
Nanci Williams, LMT #14787
All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Holistic Pelvic Care™ _Intake Form

Patient Information:

Name____________________________Date of Birth___________ Date___________

Occupation____

Source of Referral_________________________Phone/Fax of Dr./ND/DC__________
Home address____

E-Mail____

Home/Cell phone____________________________ Work phone_________________

History:

1. What concern, symptom, problem or exploration brings you here?

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2. When and how did this begin?

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3. What treatments and/or tests have you received for this concern?

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4. What are your goals for treatment?

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5. Please list any pertinent medical diagnoses/treatments related to the above:

Past Medical History

Name:____
Date:___________________________

1. Date of last pelvic exam/PAP:_____________Results:_______________________

2. Any history of abnormal PAP?__________ Date of abnormal PAP:_____________

3. OB History: # of preg________
Date/Type (vag/cesarean) of deliveries______________________________________
# of miscarriages _______ Date/Description of ea. Delivery and/or miscarriage______
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4. Please list types of birth control/length of time utilized________________________

5. Please list and date any pelvic or abdominal surgeries_________________________

Please check and date, or write **P** for present, next to any of the following ailments you have had:

_____low back pain______________________ _____pelvic/abdominal pain________________

_____menstrual pain/PMS_________________ _____prolonged bleeding/altered cycles_________

_____pain during sex_____________________ _____sexually transmitted disease______________

_____fibroids/cysts______________________ _____UTI/bladder infections_________________

_____hemorrhoids_______________________ _____constipation/irritable bowel_____________

_____tearing w/ birth____________________ _____childbirth complications________________

_____sexual abuse_______________________ _____physical/other abuse__________________

_____depression_________________________ _____cancer___________________________

_____drug abuse_________________________ _____smoking habit______________________

_____eating disorder_____________________ _____ rectocele/cystocele _________________

_____Prolapse __________________________ _____ Bladder/Urination issues ______________

6. Please describe other relevant information:

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Nanci Williams, LMT #14787

Statement of Consent

Print Name:____

Release of Information
I authorize Nanci Williams, LMT 14787 to release my medical records and discuss health related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. ______ Please initial

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. ______ 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 two 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

Pelvic Floor Evaluation and Treatment
If you are receiving a pelvic floor assessment, this may include an internal vaginal exam to assess pelvic musculature health. Subsequent and current treatment of findings may include internal vaginal massage, instruction in pelvic muscle and breathing exercises, rectal assessment and/or massage and other techniques as needed. I approve internal vaginal and/or rectal exam at the discretion of the therapist. . ______ Please initial

I understand there is no guarantee of outcome of any treatment. Clients may experience a range of effects as a result of treatment including many benefits; but also physical effects such as soreness and bleeding, as well as emotional responses to treatment. I understand and agree that if at any time I experience symptoms that concern me or difficulty integrating a pelvic session, I will promptly consult Nanci Williams and my primary care physician or counselor, as applicable.
I also understand I have the option to accept or decline to provide a witness, in addition to myself and Nanci Williams, during my session. ______ Please initial

Acknowledgement of Privacy Practices and Release of Information
I understand that Nanci Williams, LMT #14787 can use and disclose health information about me to your permitted parties, which may include written records regarding health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, and similar types of health-related information, in the course of providing care to me. I have the right to receive a written Notice of Privacy Practices should I request it. I may also request that some of my health information not be disclosed, and understand that Nanci Williams is not required by law to agree to such requests.
By signing below, I have read, fully understand, and agree to the terms of this consent form, and request and consent to receive appropriate care from Nanci Williams, LMT. I understand the nature and the purpose of the session procedures, evaluation and course of treatment. I have been given the opportunity to ask questions, and my questions have been answered to my satisfaction.

Client signature________________________________**Date**_____________________

Financial Policies and Notice of Privacy Practices

Re-Member Massage, LLC
Nanci Williams, L.M.T. #14787,
5075 SW Griffith Dr., Suite 210, Beaverton, OR 97005
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 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.
_____________ 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

BILLING INFORMATION

To maintain lower rates, insurance is not billed directly. A statement will be provided that you may send to your insurance company for reimbursement as they allow. **I do not fill out forms or in anyway respond to requests from insurance companies, which may affect reimbursement.**
Payment is due at the time of service.

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 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 of Client or Responsible Party and the Date

____
Please PRINT your Name Client and your Date of Birth

____
Client Home Address and Primary Phone