Client Intake

All questions contained in this questionnaire are strictly confidential.

Re-Member Massage LLC

For Nanci Williams, LMT #14787, independent contractor

Client Name _____**Today's Date** _____

Client Information

Address _____

City _____ State _____ Zip _____

Occupation _____

If client is a minor, signature of parent or guardian _____

Phone (day) _____(may I text you?) E-Mail _____(email you?)

Date of birth _____ Who can I thank for referring you to me? _____

Living Situation: □ Alone □ w/ partner □ w/ friends □ w/ Children □ # of Children _____

Emergency contact name and phone number _____

Primary Care Dr.'s Name and Contact Info: _____

General Health Information

What are your typical daily activities – work, home, exercise? _____

_____

What substances are you currently taking? (Prescribed medications, over the counter medications, herbs, supplements, alcohol, cigarettes, recreational drugs):_____

_____

Are you currently under a physicians care? _____ What for? _____

What do you do to relieve stress? _____

Have you ever received massage before? _____ When? _____

Why? _____ What was the outcome? _____

What did you like / dislike? _____

What are your current goals for massage? _____

Current Health Concerns Please check all that apply

Concern #1 _____

Severity □ Mild (L) □ Moderate (M) □ Severe (S)

Frequency □ Constant □ Intermittent

Symptoms □ ↑ with activity □ ↓with activity

Changes □ Getting worse □ Getting better □ No Change

Treatment Received _____

Activities Limited by Condition _____

Comments _____

Concern #2 _____

Severity □ Mild (L) □ Moderate (M) □ Severe (S)

Frequency □ Constant □ Intermittent

Symptoms □ ↑ with activity □ ↓with activity

Changes □ Getting worse □ getting better □ No Change

Treatment Received _____

Activities Limited by Condition _____

Comments _____

Health History

Please provide information for the **past 5 years** including type, approximate date and treatment

Surgeries _____

Major Illnesses _____

Injuries _____

Health Conditions Please circle any **current** and **previous** conditions

General			**Comments / Where on Body**
Pain	Numbness	Altered Sensation	_____
Headaches	Fatigue	Sleep Disturbances	_____
Infections	Swelling	Migraines	_____
Loss of Sleep		Other	_____
Skin Conditions			
Abrasions/Cuts	Rashes	Ulcers	_____
Bruises	Acne/Boils	Psoriasis	_____
Hives	Eczema	Fungus / Other	_____
Muscles and Joints			
Arthritis	Osteoporosis	Scoliosis	_____
Fractures	Sprains	Strains	_____
Bursitis	Tendonitis	Stiffness / Pain	_____
Disk Problems	TMJ syndrome	Other	_____
Cardiovascular and Respiratory			
Anemia	Angina	Arteriosclerosis	_____
Congestive Heart Failure		Heart Attack	_____
Heart Disease	Hypertensions	Irregular Heart Beat	_____
Varicose Veins	Blood Clots	Phlebitis	_____
Asthma	Lung Congestion	BP Issues	_____

Continued...

General Continued… **Comments / Where on Body**

Ankle Swelling Pace Maker Pneumonia _____

Short Breath Chest Pain Other _____

Nervous System

Concussion Head Injury Stroke _____

Anxiety Depression Epilepsy _____

Mental Disorder Alzheimer Dizziness _____

Numbness Depression Forgetfulness _____

Confusion Cold/Tingling Extremities Other _____

Endocrine System

DiabetesThyroid Other _____

Digestion and Elimination _____

Heartburn Gastric Reflux Ulcers _____

Bowel Problems Gas/Bloating _____

Urinary Tract Problems Kidney Issues _____

Incontinence Abdominal Pain Hernia _____

Colitis/IBS Liver issues Other _____

Reproductive System

Total Pregnancies _____ Total Live Births _____

Currently Menstruating _____ PMS Cysts _____

Endometriosis Hysterectomy _____

Prostate Issues Sexual Dysfunction Other _____

Cancer or Tumors

Benign Malignant _____

Allergies (Food, Chemicals, Medicines, Latex) _____

EENT

Vision Problems Contacts / Glasses _____

Hearing Problems Hearing Aids / Ear Tubes _____

Dental Problems Dentures Stuffed Nose _____

Ear Aches Ringing in Ears Sore Throat _____

Are you wearing, or have in you, any medical devices? _____

OVER

Check any of the following disease you have had

□ Appendicitis □ Malaria □ Chicken Pox □ Alcoholism □ Goiter

□ Tuberculosis □ Diabetes □ Arthritis □ Whooping Cough □ Measles

□ Mumps □ Polio □ Low Back Pain (chronic) □ Hepatitis

□ Rheumatic Fever □ HIV/Aids □ Mononucleosis □ Other

General Understanding

I understand that Massage Therapy and other related health care services 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

Informed Consent

By my signature, I verify that all information provided is true and correct to the best of my knowledge. I promise to keep my Massage Therapist updated on any changes in my health, including pregnancy, and residence. I understand that in the therapy session(s) my comfort level will always come first and that I, or the therapist, may request the treatment to stop or change for any reason.

I understand that I will receive a therapeutic massage from my Massage Therapist 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, via Re-Member Massage LLC.

_____Please Initial

Patient (or Guardian's) Signature _____ Date_____

Print _____

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