Seattle:
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Transitions Bodywork

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Please take a moment to complete this form, and sign it at the bottom of page 2. This will help us to know your health concerns, and enable smooth insurance billing for our office. Thank you.

Name:		Today's Date: / /
Address:		City/Zip:
Home Phone: - -	Cell Phone: - -	Birthdate: / /
Email Address:	Preferred Contact: Home☐ Cell☐ Email☐	
Gender: M☐ F☐ Other☐	Status: Single☐ Married☐ Other☐	
Emergency Contact:	Emergency Phone: / /	
Physician:	Physician Phone: / /	
Occupation:	Employer:	

Health Information

Yes	No	
☐	☐	Have you previously had professional bodywork? (PT, OT, massage, Feldenkrais) Which/How recently?
☐	☐	Do you wear contacts, bifocals or dentures?
☐	☐	Do you have *custom* orthotics (sport &/or dress)? Do you wear them?
☐	☐	Are you pregnant? If so, what week?
☐	☐	Do you exercise regularly or participate in any sports? If so, what kind & how often?
☐	☐	Do you take any medications? If yes, please describe:
☐	☐	Have you suffered an acute injury recently? If yes, please describe:
☐	☐	Do you have any infectious or contagious diseases? If yes, Please describe:
☐	☐	Have you ever had surgery? If yes, Please describe:
☐	☐	Have you had diagnostic imaging?
☐	☐	Do you have spinal problems? If yes, please describe:
☐	☐	Have you been limited from your preferred sleep position?
☐	☐	Do you have arthritis? If so, what type, where?
☐	☐	Do you have any areas that need special attention or avoidance? If yes, please describe:
☐	☐	Do you have any other medical conditions that your practitioner should be aware of before you start treatment? If yes, please describe:

* Initial session will involve a more extensive interview of your specific needs and concerns.

Primary Insurance Information

Primary Medical Insurance	
Plan Name:	ID#(incl prefix):
Ins. Co. Phone: - -	Group #:
Relationship to Insured: Self ☐ Child*☐ Spouse*☐ Other*☐ *Insured's Information (if other than self):	
*Name:	*Birthdate: / /
*Address:	*City/Zip:
Is there Secondary Insurance: Yes ☐ No ☐ (If yes, please request "PIP, L&I, Secondary Insurance")	

Client is responsible for gathering and completing all information in the box below prior to their first appointment, possibly by calling their insurance company.
Note ***- Failure to do so will require out-of-pocket payment at time of service.***

Insurance coverage for therapy, by a massage therapist, confirmed: Yes☐ No☐	
Barbara Alexander, LMT – In Network:☐ Out-of-Network:☐	
Coinsurance %/Copay Amount ___ Physician prescription already acquired: Yes ☐ No ☐	
Is "Pre-Authorization" or "Medical Necessity Review" required: Yes ☐ No ☐	
Yearly maximum number of treatments, or annual dollar limit for this therapy: _____ (Note – maximum number treatments may include therapies, i.e., PT, Speech, OT, etc.)	
Referring Physician:	Phone: - -

The Fine Print (please read, initial, and sign)

I certify that the above information is complete and accurate, and will notify my practitioner of any changes in my medical condition. I understand that my practitioner does not diagnose illness, disease, or any other physical or mental disorder and that this work is not a substitute for medical care.

I agree to the release of any medical information my insurer may need in order to process payment.

Please note that a referral is not necessarily a prescription. A therapy prescription is similar to a pharmacy prescription and MUST always be signed by a qualified healthcare practitioner.

*Please check your specific insurance benefits for therapy allowance. Each plan is different, and it is each patient's responsibility to understand their plan.

I understand that is my responsibility to know my coverage limits and benefits and that certain services may not be covered by my insurance under the terms of my policy. I understand that I am responsible for all bills incurred at this office, and agree to make financial arrangements with my practitioner to pay for any services not covered by my insurance policy (including co-pays, co-insurance, and deductibles). **Initial _____**

In respect for the value of professional and personal time, I understand that the following policies are my financial responsibility, not that of the insurance company:

Late Cancellations: $35.00 fee for canceling or rescheduling less than 12 hours before your appointment.

No Shows: Will be charged for one session. Cancellations made within 2 hours of your appointment will be considered a no show.

I have read the statements above, and accept the responsibilities as stated.

Signature: _____ Date: ___/___/_____

*****Please avoid:*** Wearing any perfumes, scented products such as deodorants, lotions, hair products, etc. I reserve the right to cancel and charged for a session if you arrive wearing scents. Thank you!