Katelyn Dykstra  *Massage Therapy Services*

Personal Information

Last Name:	**First Name:**	**Middle Initial:**
Date of Birth (MM/DD/YY):	Primary Phone #:	Email:
Home Address:	Street:	Apt/P.O./ RR#
City:	Province:	Postal Code:
Emergency Contact:	Relationship:	Phone:

Coverage Type

□ No Coverage □ Extended Health Benefits (Complete section below) □ Motor Vehicle Accident

□ Workplace Injury (WCB/WSBC/WSNB/WSIB)

Extended Health Benefits Information

Name of Insurance Company: _____

Name of Policy Holder: _____ Policy Holder DOB (mm/dd/yyyy):_____

Policy Holder's Relationship to Patient: _____

Policy / Claim No.: _____ ID / Certificate / Perm No.: _____

Is a doctor's referral required for massage? □ Yes □No □Unsure

If yes, Name of Physician: _____

Do you have coverage under any other plan? □ Yes □No

If yes, Insurance Company: _____

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Medical Information

Are you currently taking medication? □ Yes □No

If yes, what medication(s): _____

Are you currently pregnant? □ Yes □No Expected Due Date: _____

If yes, how many weeks along? Any complications? :_____

Have you had any orthopedic injuries/surgeries/repairs? □ Yes □No

If yes, please list dates and injuries:

_____

_____

_____

_____

Please indicate any of the following that apply to you:

□ Cancer	□ Fibromyalgia	□ Headaches/Migraines	□Stroke
□ Arthritis	□ Heart Attack	□ Diabetes	□Kidney Dysfunction
□ Joint Replacement(s)	□ Blood Clots	□Low/High Blood Pressure	□ Numbness
□ Neuropathy	□ Sprains/ Strains	□Hypo/Hyperthyroidism	□ Circulation Problems

Explain any conditions you have selected above: _____

_____

_____

_____

Do you have any allergies or sensitivities? _____

_____

Massage Information:

Have you had a professional massage before: □ Yes □ No

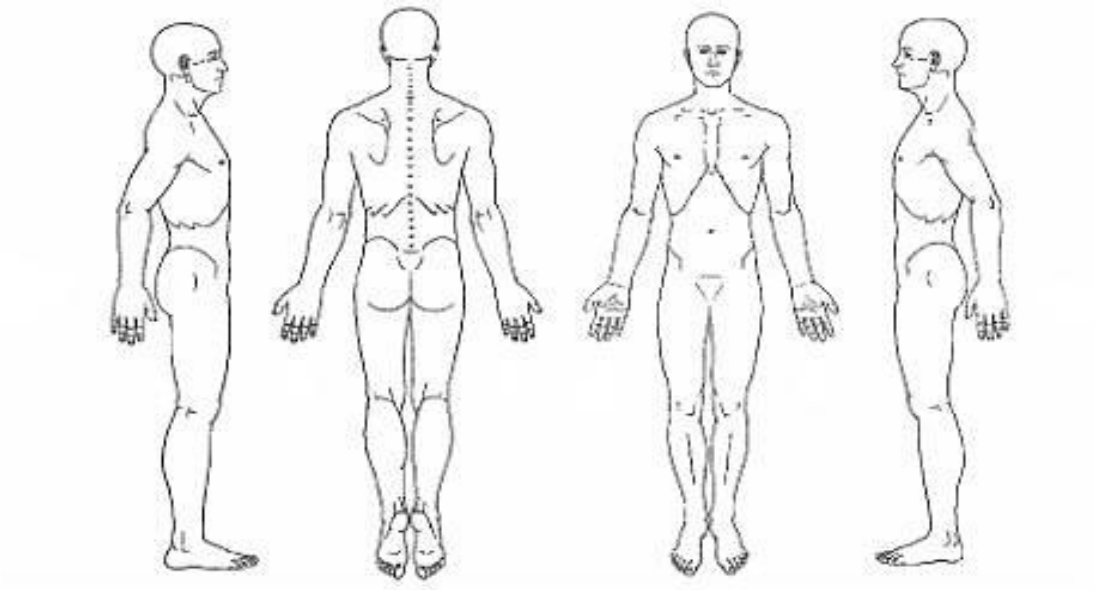
What type of massage are you seeking? □ Relaxation □ Therapeutic

What pressure do you prefer? □ Light □ Medium □ Deep □ Unsure

What are your goals for this massage? _____

P.O. Box 1438 Trenton, NS B0K 1X2 902-759-5638 DykstraDoula@gmail.com

Please circle/shade any areas of discomfort



Patient Consent for Use of Personal Information

Katelyn Dykstra Massage and Birth Services collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation regulations. If you have any questions, please contact Katelyn at 1-902-759-5638 or via email at dykstradoula@gmail.com.

We use and disclose your personal information in the following ways:

•To assess your health concerns, advise you of options and provide healthcare

•To communicate with other treating healthcare providers, including your physician, when requested

•To obtain diagnostic test results pertinent to the condition for which you are seeking treatment

•To allow us to efficiently follow-up for treatment, care and billing via phone, email, addressed mail and voicemail

•To establish and maintain contact with you

•To complete claims for insurance purposes

•To invoice for goods and services

•To collect unpaid accounts and process payments

•To comply with the law

_____
Client initial

Financial Responsibility

Katelyn Dykstra will bill your insurance carrier on your behalf when we can verify that payment will be received directly. In the following circumstances you will be responsible to pay at the time of service or product purchase:

•When you do not have any insurance that will cover the product or service

•When your insurance carrier sends payment directly to you or requires that you pay and submit your expenses

•When your coverage does not pay 100% or has been used up (you are responsible for the copayment)

•If you start treatment before getting approval for a car insurance claim

_____
Client Initial

Consent for Assessment & Treatment

I have had the chance to discuss with my Registered Massage Therapist the risks and benefits for my condition and give consent for treatment. My treatment may include manual therapy, modalities (e.g. heat, ice,), and active exercise. I understand that results are not guaranteed and that I may withdraw this consent at any time.

Consumption of alcohol, nicotine, marijuana, caffeine and/or recreational drugs are not recommended before treatment.

_____
Client Initial

_____
Therapist Signature

Cancellation Policy

We appreciate 24 hours advance notice for any cancellations and reserve the right to charge a cancellation fee (50% of scheduled appointment cost – not billable through insurance) if not adhered to.

I have read the above policies and give my informed consent below.

Name of Patient: _____ Patient Date of Birth: (MM/DD/YYYY):_____

Signature of Patient (or Guardian): _____

Date of Signature (MM/DD/YYYY): _____

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