1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.naturalcarewoodbury.com

MASSAGE NEW PATIENT INTAKE FORM

Patient Name:____Date of Birth:_____/_____/_____
(Last, First, Middle Initial)

Address:____

Phone: (C):_______________________(H):______________________ Email:___________________________________

Emergency Contact: _________________________________ Emergency Contact Phone#: ________________________

Primary Healthcare Provider and/or Clinic:____

Who referred you to our clinic?_________________________________ SSN:___________________________________

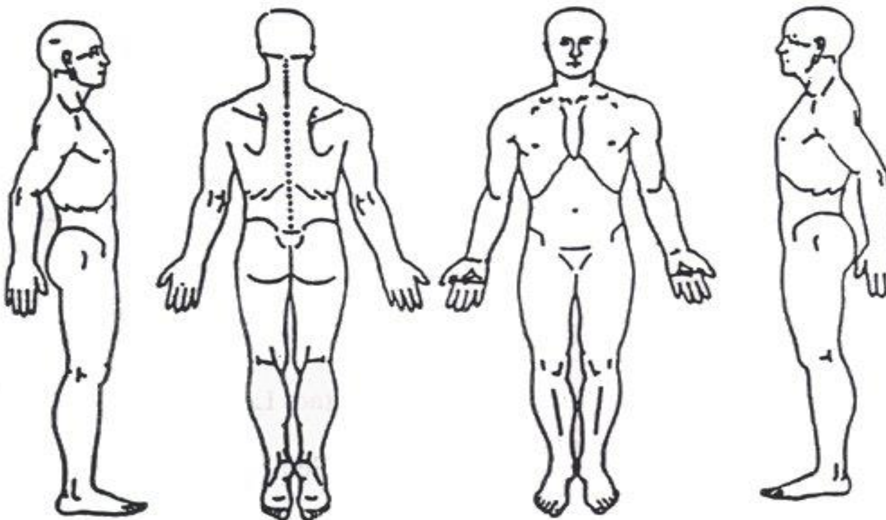
Your answers to the following questions will help us learn more about you and your health. Please take a few moments to complete the following questions; you may skip any questions you are uncomfortable with asking, or ask your provider for help with any questions.

1. What is your reason for seeking care at our clinic?____

____

2. When and how did your condition/symptoms begin?____

3. What are your goals for care?____



Please mark any body Area(s) where you have experienced pain or any other discomfort. Use the symbols below:

Numbness
=========

Pins and Needles
000000000

Burning
XXXXXXXXX

Stabbing
////////////

Aching
+++++++++

Other
****

Please grade your pain/discomfort currently from a 0 – 10 (10 being the worst pain) _____/10

HEALTH HISTORY
Please list any health problems you currently have or have had:

Cancer (malignant or metastatic):____

Diabetes (Type I or II):____

Infectious diseases (e.g. hepatitis, HIV):____

Cardiovascular (heart, circulation, high blood pressure):____

Respiratory (asthma, allergies, sinus):____

Digestive System (heartburn, IBS, appetite changes):____

Psychosocial health (anxiety, depression, eating disorders):____

Skeleton and Joint (back or neck pain, arthritis):____

Genitourinary System (kidney stones, STD's, etc.):____

Nervous System (headache, dizziness, MS, Parkinson's):____

Eyes, Ears, Nose, Throat (visual or hearing changes, dental issues):____

Immune System (autoimmune diseases, colds, etc.):____

Skin (rashes, sores, etc.):____

Women's health issues (PMS, infertility, fibroids):____

Men's health issues (prostate, erectile dysfunction):____

Other:____

FAMILY HISTORY
Please list any serious health conditions within your immediate family (mother, father, grandparents, brothers, sisters, etc.):

MEDICAL HISTORY
Please list any surgeries you have had and their date(s):

Please list any trauma(s) or injuries and their date(s):

Please list current medications:

Medication:	Dose:	Purpose:	Prescribed By:

How many children do you have?_________________________

Females only, please list:
Number of pregnancies:________________________________

Number of births:_____________________________________

Are you currently pregnant? Yes / No If yes, how many weeks?____________________

PREVENTATIVE HEALTH HISTORY
Please indicate if you have had the following health screenings within the last year?

Blood Pressure	Yes / No
Breast Exam	Yes / No
Pap Smear	Yes / No
Prostate Exam	Yes / No
Colonoscopy	Yes / No
Fasting blood glucose	Yes / No
Cholesterol	Yes / No
Dental	Yes / No
Vision	Yes / No

How often do you typically consume alcoholic drinks (wine, beer, etc.)?
Daily Some days Rare Not at all

How often do you typically consume caffeinated drinks (coffee, soda, tea, etc.)?
Daily Some days Rare Not at all

Do you use tobacco products (cigarettes, chewing tobacco, pipe, etc.)?
Yes / No In the past (year quit_______) No, never

On average, how much physical activity, exercise, or sports activities do you take part in?
None Less than 1 time/week 1-2 time/week 2-3 times/week 4 or more times/week

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MASSAGE THERAPY INFORMED CONSENT AND CAM BILL OF RIGHTS

I understand that massage therapy may be accessed for relaxation or clinical purposes depending on how the patient presents. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch.

I understand that the potential risks of massage therapy include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session.

I understand that I may be refused treatment if I appear obviously intoxicated or under the influence of drugs.

Consent I authorize the performance of massage therapy technique and procedures and understand that I will receive them from a certified massage therapist.

COMPLIMENTARY AND ALTERNATIVE HEALTH CARE BILL OF RIGHTS (CAM)

1. Name of Complementary and Alternative Health Care Practitioner: Natural Care Center of Woodbury, 1740 Weir Drive Suite 24, Woodbury, MN 55125; 651-232-6830.
2. Education Level of Massage Therapists: All massage faculty have graduated from accredited massage therapy programs and are certified massage therapists.

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIAL IS FOR INFORMATION PURPOSES ONLY.

Under Minnesota law, and unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other types of health care providers, the client may seek such services at any time.

3. As a complementary and alternative health care client, you have the right to file a complaint with the massage therapists' employer/supervisor. Any such complaint should be directed to the attention of the employer/supervisor, be in writing, and should include supporting details sufficient to permit an investigation into the complaint to commence.
4. **Office of Complementary and Alternative Health Care Compliance (OCAP), Health Occupations Program**: P.O Box 64882, St. Paul, MN 55164-0882; 651-201-3721. As a client, you may file complaints with such offices.
5. Massage is the systematic and scientific manipulation of the soft tissues of the body to prevent and alleviate pain, discomfort, muscle spasm and stress; and to promote health and wellness. Massage therapists utilize Western massage techniques from the Swedish tradition including: gliding, kneading, friction, vibration, percussion, and passive stretching, and depending on their training level, advanced techniques that address pain and dysfunction in the muscle and connective tissues. Relaxation Technique is defined as massage therapy modalities that have the intent of relaxation and general wellness. Two forms of Relaxation Technique are (1) Relaxation Technique provided for enjoyment with no clinical intent and (2) Relaxation Technique provided to produce a global outcome with clinical intent which the complexity of the case requires a higher level of critical thinking skills. Relaxation Technique modalities and methods utilized may include: Reflexology, Pregnancy Massage, Infant Massage, Geriatric Massage, healing Touch. Clinical or Advanced Technique is defined as massage therapy modalities with clinical intent that require advance training and highly skilled techniques for the purpose of meeting the patients' individual needs and are condition/injury/symptom related. The session is focused on 103 areas and coordinated within a clinical care plan that has specific short and long term goals. Clinical or Advanced Technique is often used to specifically aid in decreasing pain, increasing range of motion, and decreasing myofascial restrictions massage modalities/techniques with are more advanced and applied with a higher level of critical thinking may include: Manual Lymph Drainage, NeuroMuscular Therapy (NMT), Tigger Point Therapy, Myofascial Release, CranioSacral Therapy, and/or Reflexology.
6. Fees for massage therapy are based on increments of time and are scheduled in blocks of 45, 60, and 90 minutes. Rates for these times are $70, $90, and $130 respectively. Payment is expected at time of service by cash, check or credit card for services not covered by insurance.
7. You have the right to reasonable notice of changes in services or charges.
8. You have the right to complete and current information concerning your assessment, recommended services to be provided, including the expected duration of the services to be provided.
9. You may expect courteous treatment and to be free from verbal, physical or sexual abuse by massage therapists.
10. You records and transactions at the Natural Care Center of Woodbury are confidential, unless release of these records is authorized by you or as otherwise provided by law.
11. You have the right to be allowed access to records and written information from records in accordance with Section 144.335 of the Minnesota Statues.
12. Other massage and bodywork services may be available to you in the community. Please ask for any information you would like.

13. You have the right to choose freely among available massage and bodywork practitioners and to change practitioners after services have begun, within the limits of health insurance or other health programs.
14. You have the right to coordinated transfer of your records when there will be a change in the provider of services. You records will be transferred at your request.
15. You have the right to refuse services or treatment, unless otherwise provided by law.
16. You have the right to assert your right without retaliation from the massage therapists.

PATIENT PLEASE REVIEW * PRINT & SIGN NAME

I attest that I have received this copy of the Complementary and Alternative Health Care Client Bill of Rights.

Patient Name (print)____ Date of Birth_______________________

_____________________________ __________ _____________________________ __________
(Patient/Guardian Signature) (Date) (Translator/Interpreter Signature) (Date)

____ ______________
(Massage Therapist Signature) (Date)

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

The Natural Care Center of Woodbury is committed to patient privacy and the confidentiality of the patient information/personal health information that is entrusted to us.

The ways in which we may use or disclose your health information are detailed in our Privacy Practices.

Your Right to Limit Uses or Disclosures:
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, we will provide you with a Limitation of Use and Disclosure of Protected Health Information Request form.

Your Right to Request that Your Patient Record be Amended:
You have the right to request that we amend the information in your patient record. If you would like to amend any information in your record, we will provide you with a Request to Amend Protected Health Information form.

Your Right to Revoke Authorization:
You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOU HAVE THE RIGHT TO REFUSE CONSENT FOR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION. WITHOUR YOUR CONSENT, HOWEVER, THE NATURAL CARE CENTER OF WOODBURY WILL NOT BE ABLE TO SUBMIT YOUR CLAIMS TO INSURANCE CARRIERS OR OTHER THIRD PARTY PAYERS AND MAY NOT ACCEPT YOU AS A PATIENT/CLIENT.

By signing below, I give consent to the Natural Care Center of Woodbury's clinicians or staff to use or disclose my personal health information as stated in the Notice of Privacy Practices.

___________________________________ ___________________________________ _____/_____/_____
(Signature of Patient) (Print Name) (Date)

___________________________________ _____/_____/_____
(Signature of Authorized Representative) (Date)

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PATIENT FINANCIAL ACKNOWLEDGEMENT

Please read thoroughly. Initial your acknowledgement, then sign and print your name and the date. Thank you.

ASSIGNMENT OF BENEFITS

☐ I assign all benefits payable to me for my care at the Natural Care Center of Woodbury. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

☐ I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility.

CANCELLATION POLICY

☐ To maintain our excellence in customer service, we require a 24-hour cancellation notification for our acupuncture, massage, and Oriental medicine appointments. Please notify the clinic within 24 hours to avoid a $ 50.00 charge for missed appointments. Our Naturopathic Medicine has a no cancellation policy, patients will be charged in full for any missed appointment, not kept within the 24 hour cancellation policy. The 24 hours is within the business/working week (ex. a Monday appointment would need to be cancelled on the Friday prior).

_______________________________________ _______________________________________ _____/_____/_____

SIGNATURE (PATIENT/GUARDIAN) **PRINT NAME** **DATE**

OFFICE USE ONLY

CIRCLE INSURANCE

UHC MEDICA PREF ONE LANDMARK/CCMI (HP, CIGNA, PT. CHOICE) MEDICARE MA SELECT CARE BCBS OTHER

CHIROPRACTIC

1. Deductible/Co-Insurance?_______________
2. Is there a copay?________________
3. Limit on visits or services?_______________

- 992XX (Examination)
- 97110 (Therapeutic Exercise)
- 97112 (NMS Re-education)

- Extra-spinal Manipulation
- Laboratory
- Orthotics__________ # per year
- Orthotics not verified

- Radiology non-spinal]
- Radiology spinal

- Strapping

- 97010 (Hot/cold packs)
- 97032 (EMS Attended)
- 97035 (Ultrasound)
- S8948 (Cold Laser)
- 97012 (Machanical Traction)
- 97140 (Manual Therapy)

ACUPUNCTURE

1. Deductible/Co-Insurance?_______________
2. Is there a copay?________________
3. Limit on visits or services?_______________
4. Authorization/Precertification needed?_________

- Acupuncture benefits not verified.
- Acupuncture not a benefit on this plan.

BASED ON THE INFORMATION PROVIDED ABOVE BY THE HEALTH INSURANCE PLAN, SERVICES CHECKED ARE NOT COVERED.