MEDICAL MASSAGE THERAPY
Sara Stone LMT # 9245 • (503) 473-9518
220 E. POWELL B.L.V.D. SUIT 222, Gresham, OR 97030
Phone: (503) 473-9518 • Fax: (503) 905-8922

APPOINTMENT / NO SHOW POLICIES AND PROCEEDURES

Patient/Client: ____________________________

Appointment Scheduled:____________ ___________ ____:____ am/pm
(day) (date) (time)

Please arrive a few minutes early for your first appointment to allow time for paperwork.

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It has become necessary in our industry to charge for missed appointments. Following is an explanation of expectations and your rights regarding this matter.

I have sought massage therapy for treatment of pain and/or relaxation. In doing so, I understand that:

1. It is my responsibility to record the time and date of my appointments and to keep track of them. Although an email or text may be sent, NO reminder calls will be made.
2. If I arrive late for an appointment, I understand that I will be treated for the remainder of my scheduled time slot and will be charged for the entire scheduled time allowance.
3. If I am unable to keep my appointment, I will call as soon as I know. Preferably 24 hours. Or, in the event of an emergency, I will give as much notice as possible. I understand that I must call PRIOR to missing the appointment in order to AVOID a no show fee. At the discretion of the therapist, allowances can be made for emergencies and illness
4. Patients who fail to show up for an appointment will be charged and billed for the entire scheduled time allowance at the cash discount rate of $70.00.

I, the undersigned, have read, understand, and agree to the above policy and procedures. I understand and agree that I am financially responsible to Sara Stone, LMT, for securing time on her schedule.

Patient/Client: ________________________ Date: ______________________
(Signature)

Therapist: Sara Stone LMT Date: ______________________

Please bring this packet with you to your first appointment.

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PATIENT INTAKE FORM

Personal Information

Last Name: ______________________

First Name: ________________ MI: ___

Date of Birth: ______________________

Marital Status: ______________________

Address: ______________________

City: __________________ ST: ______

ZIP: ______ Hm. Phone: ____________

Cell or Work Phone: ______________

Email: ______________________

Please Check Employment Status:

☐ Employed ☐ FT Student ☐ PT Student

Employer: ______________________

Type of Work: ______________________

Referred By: ______________________

Referring Physician: ______________

Phone: ______________________

Insured Information

Claim#: ______________________

Insured Name: ______________________

Address: ______________________

City: ____________________ST: ____

Zip: _______Phone: ______________

Date of Birth: _________ Sex: M__ F__

Insurance Co: ______________________

Claims Rep: ______________________

Billing Address: ______________________

City: __________________ ST: ______

ZIP: _________ Phone: ___________

Date of Injury: ______________________

Please Check Type of Accident:

☐ Work Related ☐ Auto Accident ☐ Other

Attorney

Attorney: ______________________

Phone: ______________________

Regarding Insurance Billing

Once your insurance has been verified, I will be glad to bill directly to, and accept payment from, your insurance company. It should be understood that all services are charged to you, the patient, who is legally responsible for payment. Any accounts that are not covered by your insurance will become your responsibility. No Show fees are your responsibility, and are not billable to your insurance.

Authorization to Bill

I, the patient, authorize the release of any medical records or other information necessary to process this claim. I also request payment of benefits be made directly to Sara Stone LMT.

Signature: ______________________________________ Date: ________________

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MEDICAL HISTORY

Patient Name: ______________________________

How are you feeling today? ______________________________

Are you currently seeing a Doctor? Yes No

Doctor's Name:__________ Phone: (___)_________ Reason: __________

Have you ever had a professional massage? Yes No

Was the massage for relaxation or treatment purposes? ____________________

Date of last massage: ________ By whom? __________ Results? _________

Emergency Contact Name: ______________ Phone: (___)_________

What type of work do you do? ______________________________

Do you exercise regularly or participate in sports? ____________________

PLEASE MARK ALL THAT APPLY CURRENTLY (C) OR PAST (P):

Musculo-Skeletal

- ☐ surgeries ________
- ☐ accidents ________
- ☐ chronic pain
- ☐ TMJ/jaw pain
- ☐ neck pain/headaches
- ☐ shoulder/arm pain
- ☐ back or abdominal pain
- ☐ spinal/disk problems
- ☐ hip/leg/foot pain
- ☐ sprains/strains
- ☐ numbness/decreased feeling
- ☐ fibromyalgia
- ☐ tendonitis/bursitis
- ☐ bone/joint disease
- ☐ broken or fractured bones
- ☐ arthritis/osteoporosis
- ☐ breathing concerns
- ☐ varicose veins

Circulatory System

- ☐ blood clots
- ☐ low blood pressure
- ☐ high blood pressure
- ☐ heart disease
- ☐ stroke
- ☐ lymphedema
- ☐ thyroid/hormone imbalance

Immune System

- ☐ sinus problems
- ☐ allergies
- ☐ asthma
- ☐ skin disease
- ☐ allergies to oils/lotions/nuts
- ☐ open cuts or sores
- ☐ rashes/athletes foot
- ☐ HIV/AIDS/HEP C
- ☐ infectious or communicable disease

Neurological System

- ☐ seizures or epilepsy
- ☐ diabetes
- ☐ cancer/chemotherapy
- ☐ lupus
- ☐ depression
- ☐ sleep disorders
- ☐ panic/anxiety
- ☐ fatigue

Other

- ☐ wearing contacts
- ☐ pregnant
- ☐ alcohol/caffeine in last 6 hours
- ☐ any other condition ______________________________
- ☐ prescription medications ______________________________

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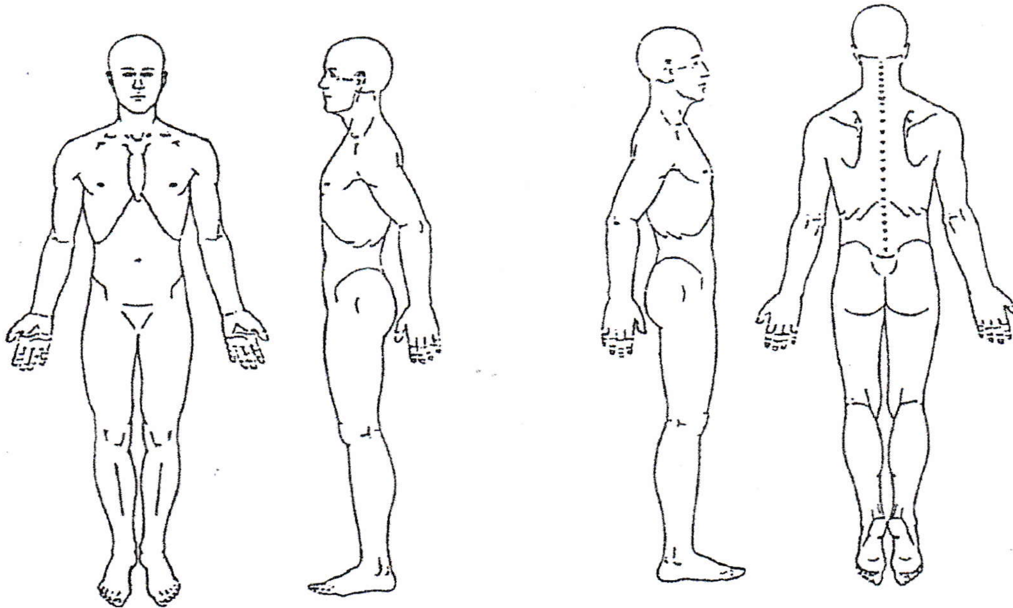
PAIN CHART

Please mark on the body, any areas where you are experiencing pain or discomfort, using the indicators listed below:

S = severe pain **M** = moderate pain **L** = low or mild pain



It is my choice to receive massage therapy. I understand that treatment is given for the well being of my body and mind. I agree to communicate with my practitioner regarding my comfort or pain levels. I also understand that both myself, as well as the massage therapist may terminate the massage at any time for any reason.

I understand that a massage therapist does not diagnose illness, disease, physical or mental disorders. Nor does a massage therapist prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see my primary health care provider for such services.

I have made the massage therapist aware of all medical conditions to the best of my knowledge and will update Sara Stone if any changes occur in my health status.

Signature: ______________________________ Date: ____________.

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FINANCIAL AGREEMENT

Please mark all that apply:

☐ I have been injured in an **auto accident**. I understand that my provider will bill my insurance company as a courtesy and is not required to do so. I have provided information regarding my insurance carrier and claim number and I authorize release of any and all information necessary for Sara Stone, LMT to be compensated for my treatment. If for any reason, my insurance company does not pay, or pay in full, I understand that I am responsible for any outstanding charges and hereby agree to make payments of $____________ (at least $50.00) per month, until account is paid in full. I understand that Sara Stone, LMT reserves the right to involve a collections agency at any point should I violate our payment agreement. If my account should become delinquent, I agree to pay for collection charges as well as interest until account is paid in full.

☐ I have been injured in an on-the-job accident and have filed a **workers compensation claim**. I understand that my provider will bill workman's compensation as a courtesy and is not required to do so. I have provided information regarding my insurance carrier and claim number and I authorize release of any and all information necessary for Sara Stone LMT to be compensated for my treatment. If for any reason, my insurance company does not pay, or pay in full, I understand that I am responsible for any outstanding charges and hereby agree to make payments of $____________ (at least $50.00) per month, until account is paid in full. I understand that Sara Stone, LMT reserves the right to involve a collections agency at any point should I violate our payment agreement. If my account should become delinquent, I agree to pay for collection charges as well as interest until account is paid in full.

☐ I am covered by **health insurance** that will cover massage therapy:

- Under my policy, the massage therapist may bill directly.

☐ I am not covered by insurance that will pay for Massage Therapy directly. I will pay cash (or check) at the time of service. However, I would like a receipt to submit to the insurance company for personal reimbursement.

☐ I have no insurance and elect to pay cash at the time of service. I will receive a cash discount from the billing rate for selecting this option. Currently $80.00

I have read and understand this policy, and have selected one of the above stated payment options.
I may ask for a copy of this agreement signed by the staff and myself.

Patient/Client: ____

Signature:____ Date: _________

Therapist: ____ Date: _________