Confidential Intake Form Christine Monroe LMP

Name_____

Date of Birth _____/_____/_____

Address_____

Phone Number_____

Email Address_____

Emergency Contact_____

Phone Number_____

Occupation_____

Medical History

1. Have you ever had a professional massage?_____
2. Are there any areas you do not want massaged? _____
3. Are you pregnant? If so how many weeks? _____
4. Do you have allergies to oils, lotions or ointments? _____
5. Please list any known allergies_____
6. Please list any medications you are currently taking_____
7. Have you recently had a injury, surgery or inflammation? If yes, please explain_____
8. Please explain any condition you marked below or any other health conditions not yet noted.

   _____

   _____

   _____

( ) Contagious skin condition

( ) Recent accident or injury

( ) Joint disorder/rheumatoid arthritis/osteoarthritis /tendonitis

( ) open sores or wounds

( ) Recent fracture

( ) Sprains or strains

( ) Diabetes

( ) Heart Condition

( ) Osteoporosis

( ) Headaches/migraines

( ) Fibromyalgia

( ) TMJ

( ) Cancer

( ) Epilepsy

Release of Medical Records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorney's, healthcare providers, and insurance case managers, for the purpose of processing my claims.

Signature_____

Date_____

Signature of parent or legal guardian (if clients is a minor)_____

I authorize the direct payment of medical benefits for services billed to Christine Monroe, LMP.

Signature_____

Date_____

Insurance Information

What type of insurance do you have that may cover you for this condition?

( ) Auto

( ) Worker's compensation/state industrial

( ) Health

Insured's full name_____

Insured's date of birth_____

Insurance ID#_____

Insured's employer_____

Do you have secondary insurance? If so please provide a copy to Christine Monroe, PLLC

_____

Financial Responsibility

We accept Visa, Master card, American Express, Discover, cash and check. Payment is due at the time of appointment. If you are using medical insurance, you will be responsible for your copay amount determined by your insurance provider. If you have a deductible that has not been met, you are responsible to pay for your massage in full until it is met then your insurance will pay a percentage specified in your contract. We will bill insurance for you. In the event your insurance denies coverage for any reason you are responsible for the balance. Returned checks will result in a $30.00 NSF charge.

Signature_____

Date_____

Cancellation Policy

We ask our clients to respectively give us 24 hour notice if you cannot make your appointment. We understand life happens and would be more than happy to reschedule you for another day. If you "no show" your appointment more than two times, you will be invoiced a $25.00 fee.

Signature_____

Date_____

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to us. The privacy of your health information will be securely maintained and your information will not be disclosed to others unless the law requires us to do so or you tell us to do so.

HIPAA, a federal law, requires that we take additional steps to keep you informed about how we may use information to provide health care services to you. A copy of the HIPAA law can be found online and copies are in the office. I have read the Notice of Privacy Protection Policy at Christine Monroe LMP, PLLC.

I received a copy _____ initial

I declined a copy_____ initial

I requested a emailed copy_____ initial