HANSON
CHIROPRACTIC & MASSAGE

Massage Therapy Intake

Name:_____ DOB:_____/_____/_____

Home Phone:_____ Cell. Phone: _____

Email:_____

Street:_____ City:_____ State:_____ Zip:_____

Insurance Carrier:_____ Claim/ID#:_____

Primary Care Provider:_____ Phone: _____

Please *check all* the symptoms below that apply to you:

Skin
- ❑ Allergies to Oils/Scents
- ❑ Rashes
- ❑ Athlete's Foot
- ❑ Warts

Circulatory
- ❑ Heart Condition
- ❑ Varicose Veins
- ❑ High Blood Pressure
- ❑ Swelling in Extremities
- ❑ Low Blood Pressure
- ❑ Breathing Difficulties
- ❑ Blood Clots
- ❑ Sinus Problems

Nervous System
- ❑ Herpes/Shingles
- ❑ Numbness/Tingling
- ❑ Chronic Pain
- ❑ Fatigue
- ❑ Sleep Problems

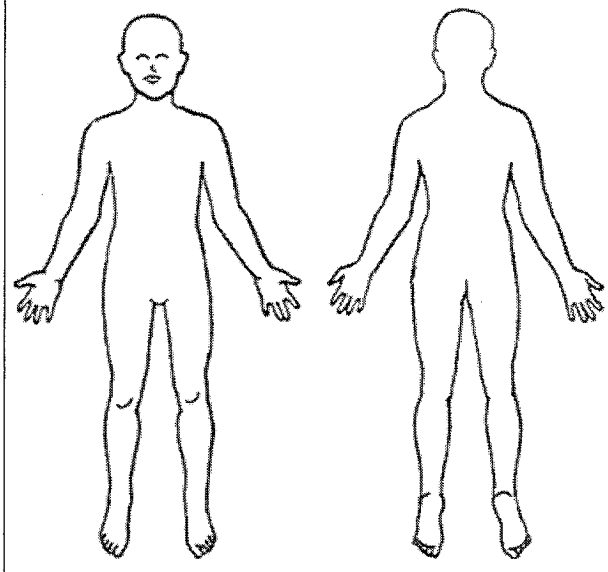
Reproductive
- ❑ Pregnant
- ❑ PMS

Digestive
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Diverticulitis
- ❑ IBS Syndrome

Musculoskeletal
- ❑ Bone/Joint Disease
- ❑ Tendonitis
- ❑ Broken Bones
- ❑ Arthritis
- ❑ Lupus
- ❑ Sprains/Strains

Other:_____

Please *circle* areas of pain below:



Previous History

Surgeries:	***Accidents/Injuries & Date(s):***	***Medications:***

Please *check* the other services offered at Hanson Chiropractic that you are interested in:

❑ Free Ideal Protein Weight Loss Consultation ❑ Free Chiropractic Consultation

By signing below:

I understand Licensed Massage Practitioners do NOT diagnose illness, disease or any other disorders; I acknowledge massage is not a substitute for a medical examination or diagnosis and it is recommended I see a primary health care provider for that service. I choose to receive massage therapy and I agree to communicate with my practitioner any time I feel like my well-being is compromised. I have provided full information regarding my medical precautions and history, and will update my LMP with any changes. I release any person or persons of any liability caused by any treatment.

Initial if treatment is being billed:_____ I authorize payment directly to Hanson Chiropractic Clinic, Inc.

Signature:_____ ***Date***:_____

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FINANCIAL POLICY

Please *initial* the payment plan that applies to you. Initial both if both apply to you.

_____ ***Cash / Time of Service***

Initial I acknowledge that I am financially responsible for my account balance and payment is due at the time services are rendered, unless other arrangements have been made in advance.

_____ ***Health/Auto/Workman's Compensation Insurance / Billed Services***

Initial I acknowledge that I am financially responsible for my account, and that payment towards deductible/co-payment/co-insurance is due at the time which services are rendered. I understand that my insurance is a contract between the insurance company and myself only. Any billing/correspondence from Hanson Chiropractic Clinic, Inc. is conducted as a courtesy to me.

I acknowledge that I am financially responsible for services that are not covered by insurance. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be due and payable *immediately*.

I have read the portion of this financial policy that applies to me.

⇨ **Patient's Signature:** _____

Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the "Notice of Privacy Practices" and have been provided the opportunity to review it.

⇨ **Patient's Signature:** _____

Date: _____

MASSAGE CANCELLATION POLICY

We ask for at least ***24 hours advance notice*** if you need to cancel or re-schedule an appointment. This enables us to contact and schedule patients who are on our wait list.

_____ **Initial** We reserve the right to charge a **$25.00** inconvenience fee for "no show" or "same day cancellations" to cover a small portion of your therapist's lost time. This fee is the patient's direct responsibility, *cannot* be billed to an insurance carrier, and will be due on your next visit.

_____ **Initial** It is the patient's responsibility to keep track of his/her scheduled appointments. The reminder calls given are a courtesy to you as our patient. In the event you did not receive your reminder call or message it does not excuse a "no show" or "same day cancellation".

We understand that extenuating circumstances may exist, so please discuss with your therapist if you need to make special scheduling arrangements or if an emergency has occurred.

I have read the above, understand the above policies and agree to them.

⇨ **Patient's Signature:** _____

Date: _____