WELLNESS DOCTOR
Natural Healthcare & Chiropractic Sports Medicine

1693 SW Chandler Ave, Ste 280 Bend, OR 97702 * P: 541-318-1000 * F: 541-318-7050

Massage Client Waiver Form

Name: _____ **DOB**: _____

Please take a moment to read and initial the following information:

_____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular and fascial tension, improvement of circulation, and energy flow.

_____ If I experience pain or discomfort during the session, I will immediately inform the licensed massage therapist (LMT) so that pressure/ strokes can be adjusted to my level of comfort. I will not hold Wellness Doctor or the LMT responsible for any pain or discomfort I experience during or after the session.

_____ I understand that the services offered today are not a substitute for medical care. I understand that the LMT, is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat physical or mental illness.

_____ I affirm that I have notified the LMT of all known medical conditions, medications, and injuries.

_____ I agree to inform the LMT of any changes in my health and medical condition. I understand that there shall be no liability on the LMT should I forget to do so.

_____ By signing this release, I hereby waive and release Wellness Doctor and the LMT from any and all liability, past, present, and future relating to massage therapy and bodywork.

Only complete the section at the bottom of this page if you are a new patient and you haven't already provided this information <u>OR</u> if your information has recently changed.

Address:_____City:_____State:_____Zip Code:_____
Primary phone: _____ **Primary E-mail**: _____
Cell phone carrier (this information is used to enable us to send you reminders for appointments via text to your cell phone)**:_____ Cell phone number:_____**
Emergency Contact: _____ **Phone**: _____ **Relation**: _____
Language: English___ Spanish ___Other___
Race: White ___ American Indian or Alaska Native ___ Asian ___ Native Hawaiian/Other Pacific Islander ___
Black or African American ___ Hispanic or Latino ___ Decline to Answer ___ Other_____
Ethnicity: Hispanic or Latino___ Not Hispanic or Latino ___ Decline to Answer___

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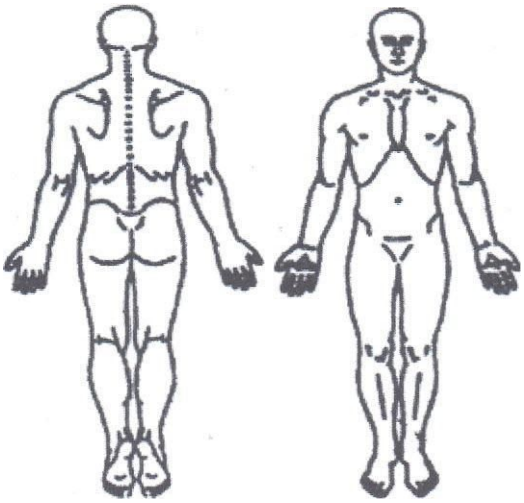

Symptom History

1. What is your major complaint? Mark with an "X" to indicate on the figure above where you are experiencing symptoms.
2. When did your symptoms begin? _____
3. Was there Trauma involved? YES NO
   If yes, describe: _____
   _____
   _____
4. Any changes in the following? YES NO
   If yes, check and describe:
   - ___Medication
   - ___Work Duties
   - ___Hobbies
   - ___Exercise (new or changed)
   - ___Body weight
   - ___Eating habits
   - ___Ergonomics
   - ___Stress
   - ___Sleep patterns

5. How often do the symptoms bother you? _____
6. Has this condition bothered you before? YES NO
7. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBING, NUMBNESS, TINGLING, CRAMPING, OTHER:**_____
8. What aggravates the condition: _____
9. What relieves it/What have you done for it? _____

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Medical History

Please check all that apply:

- ☐ Arthritis
- ☐ Allergies to coconut, eucalyptus or lavender
- ☐ Allergies, other: _____
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Contact lenses
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Eyes, ears, nose, throat problems
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder:_____
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Liver or gallbladder disease (stones)
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis, etc)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Ulcer
- ☐ Varicose veins
- ☐ Other: _____

Personal History

1. Describe your work conditions:

	None	25%	50%	>75%
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Light Labor	☐	☐	☐	☐
Heavy Labor	☐	☐	☐	☐
Prolonged postures	☐	☐	☐	☐
Repetitive Stresses	☐	☐	☐	☐
Physical discomfort	☐	☐	☐	☐
Mental stress	☐	☐	☐	☐

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2. Do you have stress in your life?
   If yes, describe:
   a. What stresses do you have? _____
   b. How do you manage your stress? _____

3. Please note the following habits:
   The following items are of importance as massage affects many systems of your body and the following habits could impact the result of your massage

	Light	Moderate	Heavy	None
Coffee				
Alcohol				
Tobacco				
Recreation drugs				

By signing below you are verifying the information contained above is correct. You are also giving permission for the licensed massage therapist to update the overseeing physician at our clinic on the progress of your condition

Client Signature: _____
Date: _____
Therapist Signature:_____

Wellness Doctor, Inc.
1693 SW Chandler Ave, Ste 280 Bend, OR 97702
P: 541-318-1000 * F: 541-318-7050 * E: Appointments@BendWellnessDoctor.com

Financial Policy

Welcome! To ensure your treatments are as stress free as possible we have established a clear financial policy.

Please read and initial next to the policy that applies to you. If you have any questions don't hesitate to ask!

____ **Insurance:** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, coinsurance or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. ***Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. ***

____ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated.

____ **Cash: Payment is due at the time of service.** A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

*Unpaid balances greater than 120 days will be sent to collections and you will be charged an additional 35% to cover the cost of collections (this amount will be added to you bill). *

I have read and understand the above Financial Policy.

_____ _____

Signature of Patient or Responsible Party **Date**

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Cancellation and No Show Policy

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires 24 hours' notice to cancel an appointment. If 24 hours is not given, a charge of $25 will be billed to your account.

If you do not show up for your appointment, you will be responsible for a $25 no show fee.

Patients that cancel 24 hours before their scheduled appointment or whose appointment needed to be rescheduled by our office will NOT be subject to a cancellation fee.

Inclement Weather Policy

Please be aware of the local forecast and if you feel that you are unable to come in for your scheduled appointment make sure to cancel 24 hours before. The above policies will be applied.

If we close the office due to weather you will receive a phone call from our reception staff and cancellation fee will not be applied.

_____ _____

Signature of Patient or Responsible Party **Date**

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HIPAA Acknowledgement of Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

*My health information may be created or received by Wellness Doctor, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

*We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

*I understand that I have the right to receive and review a written description of how Wellness Doctor, LLC will handle my health information. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Wellness Doctor, LLC and my rights regarding my health information.

*I understand that the NOTICE OF PRIVACY PRACTICES may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Wellness Doctor, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

Special Permission Request:

I give my permission for Wellness Doctor, LLC to leave messages regarding appointments on my home/cell phone answering machine.

Initial: ____ Date: _____

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver.

Initial: ____ Date: _____ Name: _____

By signing this agreement, I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before signing this consent. This release will revoke by written permission only.

I understand that I must send a written request to Wellness Doctor, LLC to revoke this release.

Signature: _____Date: _____