Health History Information

Bryant Chiropractic and Massage/ Bellevue Pregnancy Massage - Ekaterina Bryant, LMT - Lic# MA00021223
1150 140th Ave. NE, Suite 101, Bellevue, Washington 98005 Phone: 425-890-8983, email: kate@massagetherapy.com

Referred By: _____

Client Name: _____ Date of Birth: _____ Phone: _____

Address:_____ City and State: _____ Zip Code: _____

E-mail: _____ Gender: ☐ Male ☐ Female Occupation: _____

Emergency contact: _____ Phone: _____

Physician/Health-care Provider: _____ Phone: _____

Can we leave detailed voice/ text message on your phone? ☐ Yes☐ No Can we send reminder emails and detailed massages to your email? ☐ Yes ☐ No

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? ☐ Yes ☐ No

Do you have a physician referral/prescription? ☐ Yes ☐ No Are you seeking insurance reimbursement? ☐ Yes ☐ No

Type of insurance coverage: ☐ Car Accident ☐ L&I (Work Injury) ☐ Medical Health Insurance: Name and ID#_____

Have you ever received professional massage/bodywork before? ☐ Yes ☐ No How recently? _____

What kind of pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

List your current symptoms: ☐ Neck Pain ☐ Shoulder Pain ☐ Upper back Pain ☐ Mid back Pain ☐ Low back Pain ☐ Hip Pain ☐ Upper leg pain ☐ Lower Leg Pain ☐ Ankle Pain ☐Foot Pain ☐ Forearm Pain ☐ Wrist/Hand Pain ☐ Numbness/Tingling ☐ Stiffness Other:_____

List All Activities your Pain interferes with: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Working ☐ Driving ☐ Sleeping ☐ Stair climbing ☐ Child care ☐ Exercising ☐ Personal Care (washing, dressing, etc) ☐ Bending ☐ Cleaning/Cooking Other:_____

List any medications you currently take: _____

Are you wearing contacts? ☐Yes ☐No Are you wearing dentures? ☐Yes ☐No Are you wearing a hairpiece? ☐Yes ☐No Are you pregnant? ☐ Yes ☐ No

Health History

Have you had any recent or past injuries or surgeries? Please, list them below: _____

_____

Please, circle if you have any of the following conditions - blood clots, infections, congestive heart failure, contagious diseases, pitted edema.

Please indicate conditions that you have or have had in the past:

☐ Yes ☐ No Cancer _____	☐ Yes ☐ No Scoliosis
☐ Yes ☐ No Stroke, heart attack, circulatory problems	☐ Yes ☐ No Kidney disease, infection
☐ Yes ☐ No High/Low blood pressure	☐ Yes ☐ No Endocrine/thyroid conditions
☐ Yes ☐ No Epilepsy, seizures	☐ Yes ☐ No Neurological (e.g. MS, Parkinson's, chronic pain, Fibromyalgia)
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Digestive conditions (e.g. Crohn's, IBS)
☐ Yes ☐ No Swelling _____	☐ Yes ☐ No Gas, bloating, constipation
☐ Yes ☐ No Bruise easily	☐ Yes ☐ No Memory Loss, confusion, easily overwhelmed, insomnia
☐ Yes ☐ No Varicose veins	☐ Yes ☐ No Depression, anxiety
☐ Yes ☐ No Allergies: What kind? _____	☐ Yes ☐ No Dizziness, ringing in the ears
☐ Yes ☐ No Shortness of breath, asthma	☐ Yes ☐ No Headaches, Migraines
☐ Yes ☐ No Osteoporosis	☐ Yes ☐ No Numbness or tingling. Where? _____
☐ Yes ☐ No Degenerative spine/disk disease	☐ Yes ☐ No Muscle or joint pain and stiffness
☐ Yes ☐ No Arthritis (rheumatoid, osteoarthritis)	☐ Yes ☐ No Sensitive to touch/pressure
☐ Yes ☐ No Broken bones _____	Other Medical Conditions:_____

Consent for Treatment: If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____

Bryant Chiropractic and Massage/ Bellevue Pregnancy Massage
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OFFICE AND FINANCIAL POLICIES

1. 100% of your first office visit fees are payable at the time of service except for Health Insurance, Labor & Industry claims or Motor Vehicle Accidents/Personal Injury cases, where other prior written arrangements have been made.
2. All co-payments are due at the time of service, unless other arrangements have been made.
3. If you have insurance coverage, please understand that you are responsible for all charges and payment of your bill, regardless of the status of your insurance claim. We will be glad to help you in submitting your primary insurance claim for prompt reimbursement.
4. We bill secondary insurance upon prior agreement.
5. Please, inform us immediately if you have change of insurance or insurance coverage
6. In the event, if there is an overpayment by the patient, a refund will be given when insurance money has been received and a credit balance is reflected on your account.
7. Any changes or deviations from regular office charges must be in writing and signed by an authorized person.
8. Patients, late for an appointment, will be worked in or rescheduled at the discretion of the front desk receptionist.
9. Missed appointments will be documented in your treatment record. This can lead to notification of your insurance carrier, if applicable, and can result in termination of your treatment in this office. There will be a charge of $30.00 for missed appointments, which are not payable by your insurance.
10. We ask that you please silence your cell phones prior to seeing the doctor or massage practitioner.
11. We would also like to make all patients aware to the fact, that upon occasion, a fill in doctor or massage practitioner may participate in your care.
12. Be advised that if you do not have an attorney and is proceeding as a 3rd party claim, we do require a $64.00 fee for a county and satisfaction lien filing.

I have read and/or have been explained the office/financial policy. I fully understand that I am directly and fully responsible for all bills resulting from treatment. This includes any expenses, collection fees, collection costs, court costs and attorney's fees incurred in collecting any delinquent chiropractic or massage bill. I acknowledge that a privacy policy has been given to me for review.

Patient signature: _____ **Date:** _____
(Patient, Guardian*, or Authorized Representative*)

Personnel signature: _____ **Date:** _____

***Please provide documents to prove authority to sign on behalf of the patient.**

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ASSIGNMENT OF BENEFITS

I hereby assign benefits for medical/chiropractic/massage services rendered to me and I order payment by single-party check, mailed to the above named doctor/licensed massage therapist (LMT).

I hereby give to my doctors/LMTs at Bryant Chiropractic and Massage and representatives a Special Power of Attorney to affix my signature on any checks or drafts issued by an insurance agency, health or medical plan in payment for medical/chiropractic/massage services rendered to me.

I hereby authorize the release of necessary information from any medical records to insurance carriers. A Photostat copy of this assignment and authorization is as valid as the original. THIS ASSIGNMENT IS IRREVOCABLE.

In the absence of payment, the doctor/LMT is further assigned all Causes of Action and necessary rights to collect such benefits or payment. It is agreed that payment to the doctor/LMP, pursuant to this authorization by any company, shall discharge said company only to the extent of such payment. It is understood that this is payment toward the total charges for professional services rendered. The undersigned authorizes the doctor/LMP to contact the Insurance Company responsible for payment of any benefits for the purpose of determining the existing and extent of insurance benefits, and authorizes the release of any and all information in the possession of the Insurance Company necessary to determine the existence and/or extent of such benefits. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Patient's printed name Patient's Signature

_____ _____
Date Insured's or Guardian's Signature

_____
Personnel Signature