WEBBER CHIROPRACTIC SPORTS CLINIC

Massage Health History Form

Name_____ DOB_____

Address: _____

Email Address: _____ Phone #: _____

Please check all the following conditions that currently apply to you:

____ Acute Infection
____ Acute Injury
____ Allergies
____ Anxiety
____ Arthritis
____ Autoimmune Disorder
____ Athlete's Foot
____ Bruising/Bruise easily
____ Cancer
____ Cold/Flu
____ Chronic Back Pain
____ Depression
____ Diabetes
____ Digestive Concerns
____ Dizziness
____ Edema
____ Epilepsy/Seizures/Convulsions
____ Fatigue
____ Fever
____ Fibromyalgia
____ Headaches
____ Heart Condition
____ Herniated Disc
____ High Blood Pressure
____ Infectious Condition
____ Insomnia
____ Loss of Range of Motion
____ Muscle Spasms
____ Muscle Tension
____ Numbness or Tingling
____ Osteoporosis
____ Pain
____ Pregnancy
____ Skin Condition/Rash
____ Stiff Neck/Shoulders

Have you experienced professional massage? _____
How frequently? _____ Preferred pressure? _____

Describe your reason for this visit, including any current complaints and areas of tension or discomfort: _____
_____
_____

Are there any areas you would like me to avoid? _____

Do you have any known allergies? Please list all: _____
_____

Describe any regular physical activity you do and how frequent:
_____

List any medications you currently take:_____
_____

In case of emergency, contact:
Name/Phone Number: _____

Please take a moment to read the following and sign below:

I understand that the massage/bodywork I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience pain or discomfort during the 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 treatment. I understand that massage/bodywork practitioners are not qualified to diagnose, prescribe or treat 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 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 forget 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.

I understand that if I cancel an appointment within 24 hours of the scheduled appointment time, I am responsible for the cancellation fee.

Client Signature: _____ Date: _____

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HIPAA INFORMATION AND CONSENT FORM

The Health Insurance and Accountability Act (HIPAA) provides safeguards to protect your privacy.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patients' condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilized several vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning to you PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ hereby consent and acknowledge my agreement to the terms set forth in the HIPAA form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

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Insurance Non-Covered Service Agreement

Potential Reasons for Non-Covered Status:

- The service is or may be deemed investigational or experimental under the carrier's internal guidelines.
- The service is considered, or may be deemed, not medically necessary under the carrier's internal care or cost management guidelines.
- The service is not or may not actually be covered under the plan to which the above patient is prescribed.
- The service is not or may be deemed as not provided in accordance with the Provider's Agreement with the carrier or other requirements of the carrier's or managed care entity's internal guidelines.

The carrier authorizes the provider to charge the patient for the above services so long as the disclosure is made and signed by the patient prior to the services being provided.

The undersigned patient acknowledges the Non-Covered status of the proposed service(s) has been explained, and that a certain portion of the patient's care may not be covered by or has not been authorized by the patient's insurance plan. The undersigned acknowledges that if any portion of the care provided is not, or may not be, covered by insurance, then the undersigned shall be responsible for payment and shall make the necessary financial arrangements with the healthcare provider to pay for these services.

Patient Signature: _____

Cancellation Policy

At the time of your initial appointment, we require a valid debit/credit card on file for cancellation fee purposes. Webber Chiropractic Sports Clinic promises to only charge you for the following cancellation fees addressed below. Due to high demand for appointments, we require at least 24 hours' notice. A "no show" or cancellation with 24 hours' notice will result in a financial charge to you, the patient.

Charges for chiropractic:
$70 for each missed visit

Charges for massage visits are:
$50 for each missed 30-minute massage
$90 for each missed 60-minute massage
$130 for each missed 90-minute massage

I understand that twenty-four (24) hours' notice is required when canceling an appointment. I also understand that I will be directly charged for missed appointments that I do not cancel according to the cancellation policy. I understand that insurance will not pay for missed appointment fees.

Patient Signature: _____

Patient Billing and Payments

We require a patient's card on file for payments pertaining to a copay or a non-insurance rate payment to be paid at the time of services rendered (or on a payment plan made by the front desk staff). If you are unable to pay at the time of service, you will have to make an agreement with the front desk staff that is approved by the office manager. If you have not met your deductible through insurance, you can receive monthly statements for your treatment if desired. If you would like to pay at the time the services are rendered, we can put your payment card on file. We send statements via email or text message and you are directed to pay your balance using our online portal.

Patient Signature: _____

Minor Treatment Consent

Have a parent or legal guardian sign the following if you are under 18 years of age:

"I hereby authorize the Providers of Webber Chiropractic Sports Clinic to provide chiropractic or massage therapy treatments as deemed necessary for my child."

Signature of Parent or Legal Guardian _____

Printed Name of Parent or Legal Guardian _____

Functional Rating Index

For use with NECK and/or BACK problems only.

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

1. Pain Intensity:
   - **0** No pain
   - **1** Mild pain
   - **2** Moderate pain
   - **3** Severe pain
   - **4** Worst possible pain
2. Sleeping:
   - **0** Perfect sleep
   - **1** Mildly disturbed sleep
   - **2** Moderately disturbed sleep
   - **3** Greatly disturbed sleep
   - **4** Totally disturbed sleep
3. Personal Care (dressing, washing, etc.):
   - **0** No pain; no restrictions
   - **1** Mild pain; no restrictions
   - **2** Moderate pain; need to go slowly
   - **3** Moderate pain; need some assistance
   - **4** Severe pain; need 100% assistance
4. Traveling (flights, driving, etc.):
   - **0** No pain on long trips
   - **1** Mild pain on long trips
   - **2** Moderate pain on long trips
   - **3** Moderate pain on short trips
   - **4** Severe pain on short trips
5. Work:
   - **0** Can do usual work plus unlimited extra work
   - **1** Can do usual work; no extra work
   - **2** Can do 50% of usual work
   - **3** Can do 25% of usual work
   - **4** Cannot work
6. Recreation:
   - **0** Can do all activities
   - **1** Can do most activities
   - **2** Can do some activities
   - **3** Can do a few activities
   - **4** Cannot do any activities
7. Frequency of pain:
   - **0** No pain
   - **1** Occasional pain; 25% of the day
   - **2** Intermittent pain; 50% of the day
   - **3** Frequent pain; 75% of the day
   - **4** Constant pain; 100% of the day
8. Lifting:
   - **0** No pain with heavy weight
   - **1** Increased pain with heavy weight
   - **2** Increased pain with moderate weight
   - **3** Increased pain with light weight
   - **4** Increased pain with any weight
9. Walking:
   - **0** No pain any distance
   - **1** Increased pain after 1 mile
   - **2** Increased pain after ½ mile
   - **3** Increased pain after ¼ mile
   - **4** Increased pain all walking
10. Standing:
    - **0** No pain after several hours
    - **1** Increased pain after several hours
    - **2** Increased pain after 1 hour
    - **3** Increased pain after ½ hour
    - **4** Increased pain with any standing

Patient Signature:_____

Score: _____