Radiant Hummingbird Massage Therapy, PLLC

Business Address
3710 168th St NE #A101
Arlington, WA. 98223
425-268-8876

Billing address:
7823 59th AVE NE
Marysville, WA. 98270
425-268-8876

Health Information

Today's Date_____

1. Patient Information:

Patient Name:_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____Work Phone:_____

Occupation:_____Employer:_____ Social Security Number:___-___-____

Emergency Contact :_____ Phone Number:_____ Relationship:_____

Primary Care Physician:_____ Primary Care Physician and Phone: _____

Current Health Information:

Are you currently seeing a medical practitioner? Yes No

If yes, please explain: _____Date of Last Visit: _____

2. List All Pain Area/Medical Concerns: (Please circle your answer)

Is your visit based on a current injury? Yes No (If **yes**, please fill out **page 3**)

Please explain:_____ Date of Injury:_____

First/Main Concern:_____

Intensity of pain is: **Mild** **Moderate** **Severe** **Disabling**

Are the Symptoms: **Constant** **Periodic**

Explain: _____

Second Concern:_____

Intensity of pain is: **Mild** **Moderate** **Severe** **Disabling**

Are the Symptoms: **Constant** **Periodic**

Explain:_____

Additional Concern(s):_____

Intensity of pain is: **Mild** **Moderate** **Severe** **Disabling**

Are the Symptoms: **Constant** **Periodic**

Explain:_____

List Normal Daily Activities (work, home, social, recreational, family…):_____

What Activities Increase the Pain?_____

Relieves the Pain?_____

Explain how, or If these activities affect your condition: _____

What results would you like to see from your massage session (less pain, more range of motion, eased tension, etc)?

_____

Signature: _____ Date _____

Parent or Guardian Signature: _____

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Injury Information

Today's Date _____

Patient Name: _____ **Date of Injury:** _____

Insurance Company: _____ **Insurance ID:** _____

1. How did the accident occur? Auto On the Job Other: _____
2. Was a Police Report filed? Yes No

   Was a Work Incident Report filed? Yes No
3. Describe your injury and how it occurred: _____
4. Describe how you felt **during** and **immediately after** the injury: _____

   Later That Same Day: _____

   Next Day: _____

   Next Week: _____

   Next Month: _____
5. Describe any bruises, cuts, or abrasions as a result of the injury: _____
6. Are your symptoms: Getting Better Getting Worse No Change

   What makes your symptoms better? _____

   worse? _____
7. Have you lost time from work since the injury? Yes No

   List your responsibilities: _____
8. Which activities are affected by this injury (daily life, work, social, etc)? _____
9. Did you go to the emergency room? Yes No

   Were you hospitalized? Yes No
10. List Health Care Providers who have treated you for this injury, the type of treatment provided, and the diagnosis: _____

    _____
11. Have you had this type of injury before? Yes No
12. Did you have any physical complaints before the injury? Yes No
13. Did you have any illnesses or previous injuries that may have been affected by this injury?

    Yes No If yes, Explain: _____

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Billing Information

Today's Date _____

Patient Name: _____ Date of Injury (if one): _____

Provider Name: _____ Insurance ID: _____

1. Patient Information:

Address _____
City _____ State _____ Zip _____
Home Phone _____
Work/Cell Phone _____
Date of Birth _____ Male Female
Marital Status: Single Married Partnered
Relationship to Patient injured:
Self Spouse Partner Child Other

Employed Unemployed Student
Employer or Schools Name: _____
Phone Number _____ Fax
Is Patients Condition related to: _____
Employment? Yes No
Auto Accident? Yes No
Illness? Yes No
Other Accident Yes No
If Auto Accident, in which state? _____
Insurance Carrier _____
Contact _____
Group number _____

2. Attorney

Has an attorney been consulted? Yes No
Retained? Yes No
Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

3. Insured (if other than Patient)

Name: _____
Insurance ID _____
Date of Birth _____ Male Female
Address _____
City _____ State _____ Zip _____
Phone Number _____
Employer or School Name _____
Phone _____ Fax _____

4. Primary Insurance Coverage

Insurance Carrier _____
Contact _____
Group Number _____
Plan Number or Name _____
Billing Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

5. Secondary Insurance Coverage

Insured _____
Insured ID _____
Date of Birth _____ Male Female
Address _____
City _____ State _____ Zip _____
Phone _____
Insurance Carrier _____
Contact _____
Group Number _____
Plan Name or Number _____
Billing Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

6. **Assignments of Benefits -** My signature below authorizes and directs payment of medical benefits for services billed to my health care provider.
7.
8. **Release of Medical Records -** My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers and insurance case managers for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney)
9.
10. **Financial Responsibility -**It is my responsibility to pay for all services provided. In the unfortunate event that my insurance company denies payment or makes a partial payment, I am responsible for the balance. If you have contacted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the fee will be waived.

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Parent or Guardian Signature: _____

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Current and Previous Conditions

Today's Date _____

Check all Past and Current Conditions, Explain and Date in Comment Section.

General
- ○ Headaches
- ○ Pain
- ○ Sleep Disturbances
- ○ Fatigue
- ○ Infections
- ○ Fever
- ○ Sinus
- ○ Other

Skin Conditions
- ○ Rashes
- ○ Athletes Foot, Warts
- ○ Other

Allergies
- ○ Scents, oils, lotions
- ○ Detergents
- ○ Other

Habits
- ○ Tobacco
- ○ Alcohol
- ○ Drugs
- ○ Coffee, Soda, Caffeine

Endocrine System
- ○ Thyroid Dysfunction
- ○ Diabetes

Muscles and Joints
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis
- ○ Osteoporosis
- ○ Scoliosis
- ○ Broken Bones
- ○ Spinal Problems
- ○ Disk Problems
- ○ Lupus
- ○ TMJ, Jaw Pain
- ○ Spasms, Cramps
- ○ Sprains, Strains
- ○ Tendonitis, Bursitis
- ○ Stiff or Painful Joints
- ○ Weak or Sore Muscles
- ○ Neck, Shoulder, Arm Pain
- ○ Lower Back, Hip, Leg Pain
- ○ Other

Cancer/ Tumors
- ○ Benign
- ○ Malignant

Nervous System
- ○ Head Injuries, Concussions
- ○ Dizziness, Ringing in ears
- ○ Loss of Memory, Confusion
- ○ Numbness, Tingling
- ○ Sciatica, Shooting Pain
- ○ Chronic Pain
- ○ Depression
- ○ Other

Reproductive System
- ○ Pregnancy
- ○ Painful, emotional menstrual cycle
- ○ Fibrotic Cysts

Respiratory, Cardiovascular
- ○ Heart Disease
- ○ Blood Clots
- ○ Stroke
- ○ Lymphadema
- ○ High/Low Blood pressure
- ○ Irregular Heart Beat
- ○ Poor Circulation
- ○ Swollen Ankles
- ○ Varicose Veins
- ○ Chest Pain, Shortness of breath, asthma

Consent and Contract for Care:

I promise to participate fully as a member of my healthcare team. I will make sound choices regarding my treatment plan, based on the information, provided by my manual therapists and other members of my healthcare team and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform, my practitioner any time I feel my wellbeing is threatened or compromised. I accept my manual therapist to provide safe and effective treatment. I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment. I also give my consent for the massage therapist to contact me via paper, or electric correspondence. It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Authorizations of Payments and Fees:

It is customary to pay for all services on the date rendered unless other arrangements were made before your appointment. The client and the guarantor are responsible for all deductibles and co-pays at the time of visit and any other fees in accordance to insurance contracts. The client and the guarantor are responsible for all elective or none covered services and any services that are not considered medically necessary. I agree to pay a cancellation fee to Radiant Hummingbird Massage Therapy, PLLC if I fail to cancel my appointments 45 minutes prior to my original appointment time. I understand that I am unable to make future appointments until this charge is paid. I understand that if I do not show up to two consecutive appointments all further appointments will be cancelled.

I hereby acknowledge that I am fully responsible for payment as listed above.

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Parent or Guardian Signature: _____

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Discloser Form/Health Care Release Form

Today's **Date**_____ 4

Stated in our Privacy Statement, we as health care providers are to keep all personal and professional information regarding our clients completely private. In doing this, we are not allowed to leave messages to any person regarding your appointment times or changes unless permitted by the client.

List the persons you permit us to contact regarding your appointments when you are unavailable below.

Name_____Phone _____

Name_____Phone _____

Name_____Phone _____

Name_____Phone _____

Patients Release of Health Care Information

Patients Name_____ Date of Birth_____
Phone Number_____

I;_____ authorize Radiant Hummingbird Massage Therapy, PLLC to disclose my health care information with the following providers and/or companies:

Please circle all that applies...

Physician **Wellness Clinic** **Other**

Dental **Mental Health**

Radiant Hummingbird Massage Therapy, PLLC is able to release and accept information from the marked list above. Information may include: health care information, intake forms, chart notes, reports, correspondence, billing statements, scheduling or other written statements.

Revocation of prior authorizations: All medical authorizations by the patient or patients authorized representatives given before the date of this release for any reason whatsoever are hereby revoked.

Photocopy: A photocopy of this release shall have the same force and effect as a signed original.

Authorization: does not expire until I give Radiant Hummingbird Massage Therapy a written revocation letter. I understand that I can revoke this information release at anytime except to the extent where action has already been taken.

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Signature: _____Date _____

Parent or Guardian Signature: _____

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Privacy Notice

Today's Date_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please Review This Thoroughly

This page is about the laws that help keep your health information private and safe. They spell out your rights as a patient and our duties as a health care provider. Radiant Hummingbird Massage Therapy, PLLC will update this notice if there are any changes in the laws.

Our Duties:

- To follow the HIPAA Privacy and Security standards.
- To train our staff to keep health information private and safe.
- To tell you how we use and share your health information.
- To tell you when we need to, and do not need to, get your approval in writing to share your health information.
- To get a copy and inspect your health information.
- To correct and/or add on to your health information.
- To get a list of who has copies of your health information.
- To tell you how to make a complaint if you have a privacy concern without fear of being punished.

For information about HIPAA, visit:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

If you have questions, or complaints please contact:

Radiant Hummingbird Massage Therapy 425-268-8876

Washington State Health Department . . . . . www.doh.wa.gov/hsqa/Complaint.htm

I have read and understand the privacy notice:

Print Name: _____

Signature: _____ Date _____

Parent or Guardian Signature: _____