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 Phone: _____

2. Current Health Information:

Are you currently seeing a medical practitioner? Yes ☐ No ☐

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

3. List All Pain Area/Medical Concerns: (Please check off corresponding box)

Is your visit based on a current injury? Yes ☐ No ☐

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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Current and Previous Conditions

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
- ○ Lymphedema
- ○ High/Low Blood pressure
- ○ Irregular Heart Beat
- ○ Poor Circulation
- ○ Swollen Ankles
- ○ Varicose Veins
- ○ Chest Pain, Shortness of breath, asthma

Comments: _____

_____

_____

Consent and Contract for Care:

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. 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.

Signature: _____ Date _____

Parent or Guardian Signature: _____

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Discloser Form/Health Care Release Form

Today's **Date**_____

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 you 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 check all that applies...

Physician **Acupuncturist**

Mental Health **Naturopath**

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 the 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.

I understand that some information is necessary to be exchanged with my Massage Therapists to receive the ultimate healthcare. The exchange of information will be handled in person and/or by confidential phone, fax, or email.

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:

Signature: _____ Date _____

Parent or Guardian Signature: _____

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GENERAL LIABILITY RELEASE FORM

MASSAGE THERAPY SERVICES

By signing below, you agree to the following:

1) I give my permission to receive massage therapy.

2) I understand that therapeutic massage is not a substitute for traditional medical treatment or medications.

3) I understand that the massage therapist does not diagnose illnesses or injuries, or prescribe medications.

4) I have clearance from my physician to receive massage therapy.

5) I understand the risks associated with massage therapy include, but are not limited to:
- Superficial bruising
- Short-term muscle soreness
- Exacerbation of undiscovered injury

I therefore release Radiant Hummingbird Massage Therapy, PLLC and the individual massage therapist, Jacquie L Gilmore from all liability concerning these injuries that may occur during the massage session.

6) I understand the importance of informing my massage therapist of all medical conditions and medications I am taking, and to let the massage therapist know about any changes to these. I understand that there may be additional risks based on my physical condition.

7) I understand that it is my responsibility to inform my massage therapist of any discomfort I may feel during the massage session so he/she may adjust accordingly.

8) I understand that I or the massage therapist may terminate the session at any time.

9) I have been given a chance to ask questions about the massage therapy session and my questions have been answered.

Signature: _____ Date _____

Parent or Guardian Signature: _____