Patient Registration Form

Patient:_____
Last First Middle Initial

Guardian:_____

Address:_____
Street City ZIP

Phone #: _____(Home) _____(Work)

Date of Birth_____ ❑ F ❑ M ❑ Married ❑ Single ❑ Divorced ❑ Separated

❑Widow(er) ❑ Partnered ❑ # of Children _____ **Drivers License # and State**:_____

Occupation:_____ Employer:_____

Student?: ❑ Yes ❑No If Yes, ❑ Full-Time ❑ Part-Time? Where?_____

How Did You Hear About Us?

❑ Newspaper _____ ❑ T.V. ❑ Yellow Pages ❑ Web Page/Internet ❑ Friend ❑ Passing by ❑ Promotional Massage Card

REFERRED BY:_____

EMERGENCY CONTACT

IN CASE OF EMERGENCY, CONTACT: Name:_____

Relationship:_____Home Phone:_____

Work Phone:_____ Ext._____

I certify that the above information is correct to the best of my knowledge. I will provide any changed information as it becomes available. Failure to do so may result in denied charges from my insurance company, if applicable and increase my out-of-pocket expense for treatment.

Signed:_____Date:_____

PATIENT CONDITION

Reason for Visit_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ❑ Yes ❑ No ❑Unknown

What treatment have you already received for your condition? ❑ Medications ❑ Surgery ❑ Physical Therapy

❑ Chiropractic Care ❑ Massage ❑ None ❑ Other_____

Name & address of other doctor(s) who have treated you for your condition_____

_____

5/27/03

PATIENT PRIVACY NOTICE
Health Insurance Portability and Accountability Act (HIPAA)

Cascade Health Center 1165 Pearl Street Eugene, OR 97401

The staff at Cascade Health Center is dedicated in preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

As required by law, we must have your written consent before we use or disclose information for purposes of arranging for your health care, the payment for or reimbursement of the care that we provide to you and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization.

By law you have the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting or disclosure of your medical information, requesting that we communicate with you confidentially, requesting that we restrict uses and disclosures of your health information, and registering a complaint if you feel your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations by law. We may revise our Notice from time to time. The Effective Date at the top right corner of this page indicates the date of the most current Notice in effect.

You have the right to receive a copy of our most current Notice in effect. If you have not received a copy of our current Notice, please ask your health care provider and you will be provided a copy.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact us at (541) 343-0269.

I have read and understand the above Privacy Notice and sign below willingly.

_____ _____

Patient Signature Date Signed

_____

Please Print Name

Consent Form / Office Policies
Cascade Health Center

I hereby request and consent to the performance of Massage Therapy including various techniques of touch for massage or deep tissue work on me (or on the patient named below, for whom I am legally responsible) by a Licensed Massage Therapist (L.M.T.).

Massage Policy

Patient Initial Here:_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. 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 understand that the use of Alcohol and Drugs prior to a massage session is incompatible to the healing process of massage/bodywork and are grounds for refusal/termination of a session. It is also understood that any illicit or sexually suggestive remarks or actions towards the therapist or advances made by me will result in immediate termination of the session, and I will be liable for payment for the "full' scheduled appointment. There will be no sexual activity of any kind by the practitioners or the clients. ***Any actions deemed "inappropriate" by the therapist will result in permanent expulsion*** from the facility.

I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep my medical profile updated when necessary and understand that there shall be no liability on the practitioner's part should I forget to do so. The practitioners of massage at Cascade Health Center are not doctors. They do not diagnose, prescribe or practice medicine of any kind. If you suffer from any medical condition(s) you should be referred to massage by your primary care provider as some massage techniques could be contraindicated to (work against) medications or could progress your medical condition.

Office Policy

Patient Initial Here :_____Office initial: _____

APPOINTMENTS: Your appointment time is reserved for you. If you find it necessary to reschedule an appointment, ***a minimum of 24 hours notice is required*** that we might make that time available to someone else in need. For appointments cancelled or missed with less than the minimum notice, ***it will be necessary to charge $10 for each service appointment***. You will receive 1 warning before we are forced to charge for the missed appointment. Sudden illness or injuries are exceptions. You will not be scheduled for any further appointments until your late fee has been paid. If you are late for your appointment, we may not be able to extend your massage session but ***you will still be responsible for payment of your entire scheduled session***.

PAYMENT: We accept cash, local checks, and debit & credit cards backed by Visa/Mastercard. **Payment is due at time of service** unless you have a payment plan accepted by the business office. Inquire in the business office for details. We will bill your health insurance or personal injury claim, if necessary. We do everything we can to prescreen your policy coverage and limits but at times we are given mis-quotes or coverage levels can change without our knowledge. It is your responsibility to know your coverage limits and inform us of any policy &/or coverage changes. If for any reason your insurance does not cover all or part of any treatment you will be financially responsible for any unpaid balances. **I understand that my insurance policy is an agreement between the insurance company and myself. Cascade Health Center is a third party to this contract and as such has limited rights during the claim payment process. I acknowledge that Cascade is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to them for any treatment(s) I receive.**

In the event that I fail to make payment when due, this account (and any accounts I am responsible for) will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principle and interest due. I will be additionally liable for any attorney fees. Both collection agency fees and attorney fees will increase the balance I owe.

Thank you for your cooperation.

Signed:_____Dated:_____

Assignment of Benefits / Release of Records / Payment Agreement
Cascade Health Center

ASSIGNMENT OF BENEFITS Patient Initial Here:_____

To Insurance Company: _____ I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf for medically necessary treatment.

❑ Massage (Cascade Health Center)
❑ Chiropractic (Garreth MacDonald, D.C.)

Your denial or delay to do so in a timely manner will be considered just cause for me or the provider to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider(s) to file this complaint on my behalf if deemed necessary.

RELEASE OF RECORDS Patient Initial Here:_____

To Provider of Services: (please check the appropriate box)

❑ Massage (Cascade Health Center)
❑ Chiropractic (Garreth D. MacDonald, D.C.)

I hereby authorize you to release to any attorney, physician, massage therapist and/or physical therapist, or insurance company, involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained, for which I am seeking care.

Patient's Name (Print):_____

Patient's Signature:_____ Date:_____

Insurance	
Subscriber's Name: _____	Date of Birth:_____
Relationship to Patient: _____	Insurance Co.: _____
Group#: _____	ID#: _____
Is Patient covered by ADDITIONAL insurance? ❑ Yes ❑ No	
Subscriber's Name: _____	Date of Birth:_____
Relationship to Patient: _____	Insurance Co.: _____
Group#: _____	ID#: _____

HEALTH HISTORY- MASSAGE

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS

INJURIES/SURGERIES YOU HAVE HAD	DESCRIPTION	DATE
Falls/Accidents		
Broken Bones/ Dislocations		

NECK, BACK, EXTREMITIES : Check (✓) symptoms you CURRENTLY have & (x) those you HAD in the past

NECK
- ❑ pain in neck
- ❑ neck stiffness
- ❑ neck weakness
- ❑ muscle spasm in neck

SHOULDERS
- ❑ can't raise arms
  - ❑over head ❑above shoulders
- ❑ pain across shoulders
- ❑ tension in shoulders
- ❑ pain in shoulder joint

ARMS & HANDS	Right	Left
❑ weakness of arm	❑	❑
❑ pins & needles in arm	❑	❑
❑ pins & needles in fingers	❑	❑
❑ pain in upper arm	❑	❑
❑ pain in elbow/forearm	❑	❑
❑ pain in hand/fingers	❑	❑

LOW BACK
- ❑ muscle spasms in low back
- ❑ low back weakness
- ❑ low back stiffness

HIPS, LEGS & FEET	Right	Left
❑ pain in knee/ankle/foot	❑	❑
❑ weakness of leg	❑	❑
❑ leg cramps	❑	❑
❑ pain in buttocks	❑	❑
❑ pain in hip joint	❑	❑
❑ pain down leg	❑	❑

MID-BACK
- ❑ muscle spasms in mid-back
- ❑ pain between shoulder blades
- ❑ mid-back stiffness

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Please mark either "**C**" – currently or "**Y**" – yes but resolved – **(Leave the remaining conditions BLANK)**

GENERAL
- ___Diabetes
- ___Cancer
- ___Loss of Sleep
- ___Fatigue
- ___Dental Problems
- ___Jaw Pain/TMJ
- ___Hepatitis____
- ___Sinus Trouble
- ___PMS
- ___Infectious Disease
  Name_____

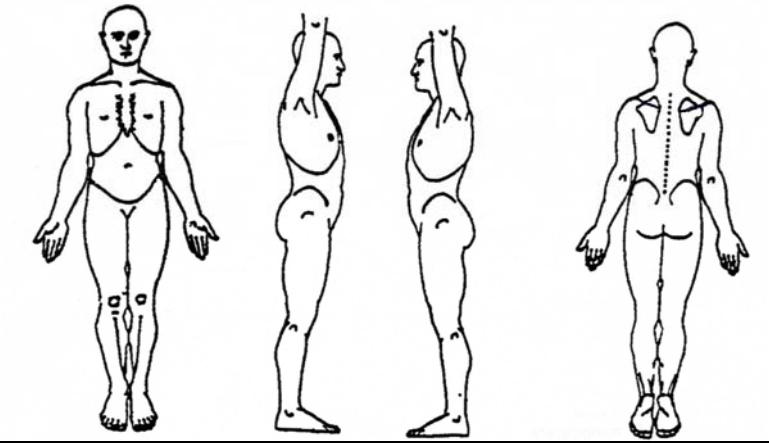
CARDIOVASCULAR
- ___Lymphedema
- ___Blood Clots
- ___Varicose Veins
- ___High/Low BP
- ___Heart Condition

SKIN
- ___Scars Location
- ___Bruising Easily
- ___Athlete's Foot/Rashes
- ___Itching
- ___Skin Cancer

MUSCULOSKELETAL
- ___Bone and Joint Disease
- ___Tendinitis/Bursitis
- ___Low Back Pain
- ___Swollen Joints
- ___Painful Joints
- ___Muscle Aches/Soreness
- ___Spinal Curvature
- ___Arthritis
- ___Headache

NEUROLOGIC
- ___Vertigo
- ___Fainting
- ___Dizziness
- ___Epilepsy/Seizures
- ___Falls/Loss of Balance
- ___Sleep Disorder
- ___Numbness/Tingling
- ___Chronic Pain
- ___Herpes/Shingles

FEMALES: Are you Pregnant? ❑ Yes ❑ No Weeks?___



Please use the following to illustrate your pain.
- Aching
- Stiffness
- Pins &Needles or Burning
- Numbness or Tingling

Have you had any bodywork/massage before? What type & When?_____
Where in your body do you "collect/store" stress/tension?_____
What results do you want from your massage sessions?_____
Are there areas of your body you prefer NOT to be massaged?_____
Do you participate in regular relaxation? How?_____Are you wearing contacts? ❑Yes ❑No

Name:_____ **Date:**_____