ALASKA MASSAGE CLINIC
Therapeutic & Medical Massage

PATIENT INFORMATION

Legal Last Name | Legal First | Middle

Birth date: / /	Social Security #	Sex: ❑ M ❑ F	Would you like apt reminders via text, email, or phone call? ❑ Email ❑ Call ❑ Text Cell Phone Carrier:

Primary Care Providers Name:	Occupation:	Email:

Mailing Street Address:	City:	Hm. Phone: ( )
	State: Zip:	Cell Phone: ( )

How did you hear about us? ❑ Drive by ❑ internet ❑ another medical office ❑ Event ❑ Friend/family ❑ Other: ______________________

INSURANCE INFORMATION

Primary Insurance Company: Policy Number:	Secondary Insurance Company: Policy Number:

HEALTH HISTORY

Please list all current medications (OTC/Prescription/Vitamins):	Please list allergies:
Have you experienced any recent trauma? (MVA, falls, etc) ❑ **NO** ❑ **YES, PLEASE EXPLAIN:**	

Are you pregnant? ❑ Yes ❑ No If yes, how far along are you?

History Please check conditions or symptoms you currently have or have had in the past:

☐ HIV/AIDS	☐ Poor Circulation	☐ Epilepsy	☐ Arthritis	☐ Rheumatic Fever	☐ Numbness
☐ Nerve Damage	☐ Hepatitis	☐ Ulcers	☐ Heart Disease	☐ Diabetes	☐ Migraines
☐ Jaw Pain/TMJ	☐ Multiple Sclerosis	☐ Gout	☐ Pace Maker	☐ Polio	☐ Tendonitis
☐ Whiplash	☐ Varicose Veins	☐ Malaria	☐ Tumors	☐ Osteoporosis	☐ Typhoid Fever
☐ Cancer	☐ Blood Clots	☐ Measles	☐ Stroke	☐ Scoliosis	☐ Tuberculosis

Operations Surgical interventions, which may or may not have included hospitalization:

☐ Cancer	☐ Bypass Surgery	☐ Appendix	☐ Hip Surgery	☐ Hysterectomy	☐ Arm/Wrist
☐ Spinal Surgery	☐ Shoulder Surgery	☐ Knee Surgery	☐ Neck Surgery	☐ Cosmetic, what specifically:	

Family History Are there any hereditary issues that you would like us to know about or that may be affecting your current concern?

Social History Please indicate below regarding your health habits:

Alcohol Use	○ Daily	○ Weekly	How much: ______________	Exercising	○ Daily	○ Weekly	How much: ______________
Caffeine Use	○ Daily	○ Weekly	How much: ______________	Pain Relievers	○ Daily	○ Weekly	How much: ______________
Tobacco Use	○ Daily	○ Weekly	How much: ______________	Water Intake	○ Daily, on average, how many ounces: ___________		

CONDITION HISTORY

The symptom(s) that prompted you to seek care today are:	Pain Scale (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10

Onset When did you first notice your current symptoms?	**Radiating** Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?

What do you think caused these symptoms?

Aggravating/relieving factors What makes it better/worse, i.e. position, time of day, movements, certain activities etc?

Worse: **Better**:

Prior Interventions Have you done anything to relieve the symptoms? ○ prescription meds ○ over-the-counter meds ○ homeopathic remedies ○ physical therapy ○ chiropractic ○ surgery ○ acupuncture ○ massage ○ ice ○ heat ○ Other: **Where**:

What else should your provider know about your current condition?

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Discloses of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be use, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information is order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patient at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect, Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates: Requires Uses and Disclosers; Under the Law, we must make disclosed to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Sections 164.500.

Other Permitted and Required Uses and Discloses Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action to reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

<u>You have the right to inspect and copy your protected health information.</u> Under federal law, however, you may not inspect or copy the following records; psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

<u>You have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family member or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want to restriction to apply.

You physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us;</u> upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

<u>You may have the right to have your physician amend your protected health information.</u> If we deny your request for amendment, you have the right to file a statement of disagreement with use and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

<u>You have the right to receive an accounting of certain disclosures we have made, If any, of your protected health information.</u>

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complain. **<u>We will not retaliate against you for filing a complaint.</u>**

This notice was published and becomes effective on/or before **<u>April 14, 2003.</u>**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name ______________________________ Signature: ________________________________ Date: _______________

ALASKA MASSAGE CLINIC
Therapeutic & Medical Massage

FEES AND CONSENT FOR SERVICES AT PAYNE CLINICS, LLC DBA ALASKA MASSAGE CLINIC

THERAPY:	Medical Massage	$240 per hour
	Relaxation/Therapeutic massage	$110 per hour

Cancellation Policy: Alaska Massage Clinic has a 24-hour cancellation policy/rescheduling policy. If you miss your appointment, cancel, or change/reschedule your appointment with less than 24-hour notice, you will be charged the following: First time: $50.00 After 1st time: $110.00

This policy is in place out of respect for our therapists and our patients. Cancellations with less than 24-hour notice are difficult to fill. By cancelling last minute, or no showing an appointment, you prevent someone else from being able to schedule in that time slot.

**All treatment/supply fees are within the customary, normal and usual range for services in the State of Alaska.
Be Informed: Massage does not involve prescription of drugs or medicines, nor the use of surgical procedures. The practice of massage is not an exact science but relies upon information related by the patient and gathered during consultation, and the therapist's interpretation thereof, as well as the therapist's judgment, experience, and expertise in working with like cases. In this clinic, all patients are only accepted on a voluntary basis. There is no forced or mandated procedure or treatment; the patient is free to ask questions and decline any specific exam or treatment procedure. In turn, the therapist is free to decline specific treatment or procedures if the patient elects to refrain from recommended efforts. There is a risk involved in almost all activities, including massage. No health professional can guarantee a specific result. Each patient should be mindful of his own symptoms and should secure a medical opinion if he has any concern as to the nature to his illness or injury; your therapist will, of course, provide expert opinion regarding massage conditions. In some cases, underlying, physical defects, deformities, or pathology may render the patient much more susceptible to injury. This is one reason why it is the responsibility of the patient to make it known or to learn about the conditions which may not otherwise come to attention of the therapist. There are certain complications which may arise during the course of care, including bruising, skin irritation, soreness, swelling, aching, and temporary pain or discomfort. These complications are extremely rare occurrences. Such normal procedures as history, consultation and palpation will aid your therapist in his effort to provide you with his best services for your individual situation. Techniques, sometimes considered experimental, such as soft tissue work, myofascial work, trigger point work, may also be recommended or utilized as part of the conservative, non-invasive approach.

Patient Commitment: I understand that each patient is a unique individual and will respond as such. I agree that an undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment. I understand that the therapist will use his hands or an instrument directly upon my body to work soft tissues. It is not reasonable to expect my therapist to anticipate, or explain, all possible risks, complications, or details of a given procedure on any particular visit, and I wish to rely on the therapist to exercise his personal professional judgment during the course of any procedures on which he feels at the time is in my best interest. I desire and agree to open and accurate communication between me, the therapists and staff. I understand there may be alternatives to handling my condition, and I freely choose to participate in the efforts I select at the Alaska Massage Clinic.

Questions: The patient should discuss any questions or problems with the therapist before signing this document.

Agreement & Consent: This certifies that I have read, understood and agree to all of the above. I agree and consent to the current normal fee structure in this clinic. I also request and consent to the procedures and treatment(s) to be rendered to myself in the Alaska Massage Clinic and understand I am to decline or terminate same at any time I clearly make it known to my treating therapist.

Assignment & promise to pay: I hereby irrevocably assign payment directly to the Alaska Massage Clinic for expenses otherwise payable to me as determined by the insurance company. I understand that I am personally responsible to the Alaska Massage Clinic for all fees that I incur. Should my account become delinquent and be turned over to a collection agency, I promise to pay an additional **40% collection fee** on the delinquent balance only. Authorization to release, at therapist's discretion, any information regarding my case or this claim is also granted. A copy of this document shall be considered as valid as the original.

Print Name ________________________________Signature:__________________________________Date: ________________