

INSURANCE INFORMATION

Date: _____

Client: First Name: _____ M.I.: _____ Last Name: _____

Address: _____

Social Security#: _____ Marital Status: _____

Name of Employer: _____

D.O.B.: _____

Insurance Company: _____

Ins. Co. Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Insurance Contact Person: _____

Insurance Claim Number: _____

Policy Number: _____ Group or I.D.#: _____

Subscriber: First Name: _____ M.I.: _____ Last Name: _____

Subscriber S.S.# _____ D.O.B.: _____

Name of Employer _____

Referring Dr. _____ I.D.# of Ref. Dr. _____

Ref Dr. Address: _____

Is this your Primary Care Provider? _____ if no, please provide name: _____

Ref. DR. phone #: _____ Date of Injury: _____

Diagnosis by DR.: _____ ICD-9 code: _____
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Private Health Insurance

Actively enrolled yes no

Waiting period yes no

Benefit Limit _____

Massage Benefits grouped with _____

Deductible _____ has been met? yes no

Copay amount _____ or % insurance pays _____

Contracted Fee (if applicable) _____

INITIAL INJURY EVALUATION

TIME OF INJURY:

1. When did the injury occur (date, time and place)?
2. How did the injury happen? Describe onset.
3. What symptoms did you experience *immediately* after injury?
4. Describe pain (ex: sharp, stabbing, shooting, dull ache, throbbing, etc).
5. Describe pain levels for each symptom (severe, moderate, light).
6. What did you do *immediately* following injury?

FOLLOWING INJURY:

1. Have you seen any other health care providers? If so, whom?
2. Are you receiving any adjunctive therapies for this injury?
3. What symptoms have you been experiencing since injury?
4. Describe pain levels for each symptom:
5. What, if anything, makes symptoms worse?
6. What, if anything, makes symptoms better?
7. Are there any particular activities that you are unable to do or that you cannot perform at your normal level due to injury?
8. Have you missed any work due to injury?
9. What physical duties are required for your job?

CURRENTLY:

1. What symptoms are you experiencing today?
2. Describe pain levels for each symptom:
3. Are you currently taking any medication? If so what?
4. What is your mental state today?
5. What results are you hoping to get from your massage?

RECORDS RELEASE

Client Name: _____

Address: _____

SS#: _____

D.O.I.: _____

Name of Insured (if applicable): _____

Claim/Policy #: _____

I, _____ authorize _____

to release chart notes/case records concerning my illness and or treatment during the period

_____ to _____; to be sent to the following person or company:

Signature: _____ Date: _____

Witness: _____ Date: _____

Business Policy

Barbara Loomis, LMT
503-341-0663

Appointments: An appointment is a time set-aside for you and it is a time, which is carefully planned within the context of the week's schedule. My time is very important to me, as I am sure yours is to you. Missed appointments or short notice cancellations are times I could have scheduled someone else, therefore without advanced notice it becomes an income loss for me. Please notify me at least 24 hours in advance to avoid being charged if you have to cancel your appointment. This courtesy enables me to re-arrange my time.

When you make an appointment, I schedule that block of time for your session. In order for me to stay on schedule out of a courtesy for others and yourself I need to stay within that block of time. If you are late for the appointment, I will use the remaining time in the most productive way, and the total fee for the session will be charged to you. My main priority is to help you in the best way that I can, so it is to the benefit of both of us if you can arrive on time. I know sometimes things happen that are out of our control and if I happen to have extra time I am always happy to spend it with you at no additional charge.

Fees: 90 minutes=\$108.15 60 minute sessions= \$77.25

With cash discount total is- 90 minutes=\$105 60 minutes=\$75

The above fees are for payments received on the *same* day of service and without the cash discount. I offer a **3% discount for cash payments on services**. Payments are due on the date of service in the form of cash, check or credit card. Payments made after date of service will be billed at \$28 per 15-minute increment. There is a \$25 check return fee.

Type or Print Name: _____

Phone Number _____

Signature _____

Email Address _____

I will never share your information with anyone.

“Like” Nurturance on Facebook to receive updates, tips and announcements of sales.

Date _____