Lesley's Therapeutic Massage
360-620-8168
9951 Mickleberry Rd, Suite 215, Silverdale 98383

Personal Data:
Name:___________________________________Date:___________Referred by:______________
Email:___________________________________ Cell Phone:______________________________

Massage History/Treatment Information
Have you received a professional massage?________If yes, frequency:______________________
What results do you want from your massage?____
Are you under the care of a Doctor, Chiropractor, Psychologist, Naturopath Doctor, or other?______If so, please explain:____
Please list current medications:____

Health History (Please circle all that apply)

MUSCULOSKELETAL
Bone or joint disease
Tendonitis
Bursitis
Broken/Fractured bones
Arthritis
Sprains/Strains
Low back, Hip, Leg pain
Neck, Shoulder, Arm pain
Headaches/ Head Injuries
Spasm/Cramps
Jaw Pain

CIRCULATORY
Heart Condition
Varicose Veins
Blood Clots
Low Blood Pressure
High Blood Pressure
Allergies
Breathing Difficulty
Sinus Problems

INFECTIOUS DISEASE
Disease name/s:_____________

OTHER
Cancer/Tumors
Diabetes
Eating Disorder
Depression
Drug/alcohol addiction
Nicotine/caffeine addiction

SKIN
Allergies
Rashes
Warts

DIGESTIVE
Constipation
Irritable bowel Syndrome
Gas/Bloating
Diverticulitis
Other

NERVOUS SYSTEM
Herpes/Shingles
Numbness/Tingling
Chronic Pain
Fatigue
Sleep Disorders
Other

REPRODUCTIVE
Pregnant? How many weeks?
PMS

SURGERIES/CAR OR SPORT ACCIDENTS
____
____
____
____
____
____
____
____
____

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Patient Name:________________________________Birthday:_________________________

Address:____________________________________City/State/Ziap___________________

Work Phone_________________________________Home Phone______________________

Emergency Contact:_________________________Emergency Contact Phone_____________

Financial and Cancellation Policy

Cancellation Policy: Appointments cancelled less than 48 hours beforehand will be charged the amount for the office visit. (Emergencies will be handled on a case by case basis.) Insurance clients will be billed personally for missed appointments.

No Show Policy: If you do not call and cancel your appointment, you will be charged the full amount of the time reserved for you. (Emergencies will be handled on a case by case basis.) Insurance clients will be billed personally for missed appointments.

Financial Policy: I ask that my clients pay at the end of each visit, unless other specific arrangements are made.

Release of Benefits and Information: I authorize Lesley's Therapeutic Massage to release any information required for this claim. I understand and agree health insurance, auto claims, workmen compensation is a contract between me and my insurance carrier. Any amount authorized to be paid directly to my therapist will be credited to my account upon receipt. However, I understand and agree that all services rendered to me are charged directly to me, and I am personally responsible for payment. Billing the insurance carrier is my responsibility. Any assistance in billing my insurance, provided by Lesley's Therapeutic Massage, is being provided as a courtesy only. Claims balance over 30 days may incur a billing fee of 1% per month (12% APR). Initials: _____

Collection Procedures: I recognize if account is in rears, collection procedures will begin. I will be responsible for all cost of collection, liens, court cost, and attorney fees incurred by Lesley's Therapeutic Massage in settlement of this case.

Acknowledgement receipt of Notice of Privacy Practices: my initials indicate that I understand Lesley's Therapeutic Massage will not disclose or sell my personal information. I also understand that I can allow or disallow any individuals from viewing or requesting my medical records. I do not want the following individuals accessing my personal health information: ____

Signature: ____________________________________Initials:_______Date:_____________
(Parent sign for minors)