North Sound Massage Therapy, LLC

Toby Ann Williams, LMP, MMP
Phone 425-328-6115 / Fax 888-200-6642
www.NorthSoundMassage.com

Name _____ How did you hear about us? _____

Address _____

E-Mail _____ Date of Birth ___ /___ / ____

Phone _____ Cell / Other _____ Text Message? ▢ yes ▢ no

Emergency Contact _____ Phone(s) _____

Marital Status: ▢ single ▢ married ▢ other **Employment status:** ▢ employed ▢ full-time student ▢ part-time student

Massage and Medical History

Have you received professional massage before? ▢ no ▢ yes - date of last session / frequency _____

Your health is very important, please check all that apply:

▢ Previous surgeries / accidents (and dates) _____
▢ Bone or Joint Disease _____ ▢ Arthritis _____
▢ Tendonitis / Bursitis (where?) _____ ▢ TMJD _____
▢ Spinal Problems _____ ▢ Headaches (frequency?) _____
▢ Migraines (frequency / triggers?) _____ ▢ Cancer / Tumors _____
▢ Joint replacement _____ ▢ Heart Condition _____
▢ High / Low blood pressure _____ ▢ Phlebitis _____
▢ Blood Clots _____ ▢ Thrombosis / embolism _____
▢ Lung disease _____ ▢ Chronic episodes of depression / anxiety __
▢ Diabetes _____ ▢ Restless leg syndrome _____
▢ Allergies _____ ▢ Sinus problems _____
▢ Digestive Issues _____ ▢ Edema _____
▢ Numbness & / or tingling - ▢ arms ▢ legs ▢ feet _____
▢ Pregnant - due date __ / __ / ____ ▢ Complications? _____
▢ Other _____

Medications: Please list **ALL** over the counter and prescribed medications you are taking.

_____

_____

Client Agreement: It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments, I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes to my health status.

Initial _____ Date _____

Assignment of Benefits: I am responsible for all services provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discounted rate for services, the amount remaining will be waived and I will not be asked to pay the balance.

I authorize and direct payment of medical benefits to my massage therapist, Toby Ann Williams LMP, North Sound Massage Therapy, LLC for services billed.

Signature _____ Date ____ / ____ / _____
*** _____ Check if you are the parent or legal guardian of client, if a minor.**

HIPAA - Compliant Operations: Your privacy is important to us. Your personal information will be protected in compliance with federal law under the Health Insurance Portability and Accountability Act of 1996. If your personal file needs to be reviewed by anyone outside (ie. insurer, attorney) you will need to sign a release form.

Practice Communication. By agreeing to receive services, you are opting in to receive education and announcements about the practice via mail or email. Your personal information is never shared nor sold to third parties, in compliance with HIPAA.

Initial _____ Date _____
*** _____ Check if you are the parent or legal guardian of client, if a minor.**

Release of Medical Records: I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, health care providers, and insurance case managers for the purpose of processing my claims.

Initial _____ Date _____
***_____ Check if you are the parent or legal guardian of client, if a minor.**

My signature below confirm that:

- I have stated all medical conditions that I am aware of and will share any change in my health status,
- I am aware of clinic policies, including cancellation and no-show fees,
- I accept full financial responsibility for all services provided, including fees outlined above, and
- This consent form is valid for today and all subsequent sessions, unless revoked in writing by me.

Client Signature _____ Date Signed ____ / ____ / ____
Printed Name _____

North Sound Massage Therapy, LLC
17090 Avondale Way NE, Redmond, WA 98052

Payment and Cancellation Policy

In an effort to provide all of our clients with outstanding service, 24 hours notice is required for all cancellation notices and rescheduling requests. Please respect our time and our other clients' requests by providing us with 24 HOURS NOTICE:

- **If you do not show for a scheduled appointment** without cancelling, you will be charged the full fee of the scheduled service.
- **If you cancel with less than 24 hours notice,** you will be charged half the fee of the scheduled service.
- **If you are more than 10 minutes late** for a scheduled appointment, you may be required to reschedule and the rescheduling fee may apply. Alternatively, you may receive treatment for the remaining balance of the scheduled appointment and you will be charged for the full fee of the scheduled service.

  ** We reserve the right to treat each situation on a case-by-case basis.

Payments are due at the time of your session or within 30 days of receipt of the invoice. Returned checks will be subject to the maximum fee allowed by law. Unpaid balances over two months past due will incur a late payment fee of $10.00 per month. Detailed statements for third-party reimbursement (for example, a flexible spending account) are available upon request.

Insurance. Every effort will be made to collect billable charges from your insurance company. However, we reserve the right to wait no more than 90 days following any billing procedure: should payment be delayed or refused, you will be invoiced directly and responsible for paying all charges within 30 days of receipt of the invoice. **Your insurance company <u>requires</u> that you pay the copayment, coinsurance, or deductible as noted by your insurer on the EOB** (explanation of benefits) - you and your provider both receive copies of the EOB from your insurer. All insurance eligibility, coverage and limitations should be verified prior to your first treatment session. You are responsible for all charges incurred from treatment prior to coverage verification. We reserve the right to not re-bill secondary carriers. **Your copayment is due at the time of service.**

By signing below, you are acknowledging your financial liability for your requested services.

Client Signature: _____ Date: ____ / ____ / _____

Printed Name: _____

Insurance Information

If your insurance covers massage, call your insurer to verify your benefits, and provide the below information.
Please provide the following to copy for your file:* ***driver's license, massage referral form if needed, insurance card.*

Policies. Every effort will be made to collect billable charges from your insurance company However, we reserve the right to wait no more than 90 days following any billing procedure; should payment be delayed or refused, you will be invoiced directly and responsible for paying all charges within 30 days of receipt of the invoice. **Your insurance company requires that you pay the copayment, coinsurance, or deductible as noted by your insurer on the EOB** (explanation of benefits) - you and your provider both receive copies of the EOB from your insurer. Insurance eligibility, coverage and limitations should be verified prior to your first session. You are responsible for all charges incurred from treatment received prior to coverage verification. We reserve the right to not re-bill secondary carriers.

Insurance ID number _____ Policy Group / FECA number _____
Insurance Plan Name _____ Employer or School Name _____

Are you the primary insured on the policy? ▢ Yes - if NOT, please provide the following for the primary insured:
Name _____ Date of Birth ____ / ____ / _____
Address _____

Is there another / secondary health benefit plan? ▢ No - if yes, please provide the following:
Name _____ Date of Birth ____ / ____ / _____

Insurance ID number _____ Policy Group / FECA number _____
Insurance Plan Name _____ Employer or School Name _____

Are you receiving treatment today due to an accident or injury? ▢ No - if yes, please provide the following:
Date of injury ____ / ____ / ____ Where (state) _____ Unable to work? (Dates) _____
▢ **Employment related:** L&I claim number _____ Employer _____
▢ **Auto accident:** Insurance company _____ Primary policyholder _____
Claim number _____ Policy number_____
Representative / adjuster _____ Phone _____ Fax _____
Address for sending claims _____
▢ **Third-party / personal injury:** Insurance / payor _____ Claim # _____
Contact / attorney _____ Phone _____ Fax _____
Address for sending claims _____

My signature below confirms that:

- I am giving permission to communicate with my insurer or other payor and any referring physician,
- I am aware of clinic policies, including cancellation and no-show fees, outlined above,
- I accept full financial responsibility for all services provided, including fees outlined above, and,
- This consent form is valid for today and all subsequent sessions, unless revoked in writing by me.

Client Signature _____ Date signed ____ / ____ / _____

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