Smokey Point Massage Therapy, LLC
16404 Smokey Point Blvd., Suite 307
Arlington, WA 98223

360-653-0950

Confidential Health History Form

Massage Therapy

Name: _____ Home #: _____ Cell #: _____

Address: _____ Email: _____

_____ City: _____ State: Washington Zip: _____

Date of Birth: _____ Sex: ◯ Female ◯ Male Marital Status: _____

Emergency Contact: _____ Phone #: _____

Occupation: _____ Employer/School: _____ Work #: _____

Have you previously received massage therapy? ◯ Y ◯ N Allergies to scents/oils? _____

Name and # of other healthcare practioners you are presently seeing and their speciality:

Do we have your permission to consult with them as necessary? _____

Briefly describe your primary health concern(s) or complaint(s):

Please check if you have or have had in the past any of the following:

- ☐ Diabetes
- ☐ Cancer
- ☐ HIV/Aids
- ☐ Arthritis
- ☐ Other (note below)
- ☐ High Blood Pressure
- ☐ Varicose Veins
- ☐ Heart Problems
- ☐ Currently Pregnant?

Indicate Level of Consumption

	None	Light	Moderate	Heavy
Exercise	◯	◯	◯	◯
Salt	◯	◯	◯	◯
Sugar	◯	◯	◯	◯
Caffeine	◯	◯	◯	◯
Tobacco	◯	◯	◯	◯
Alcohol	◯	◯	◯	◯

Please provide additional information containing those items checked or any other specific health-related conditions, including injuries, you currently have or have had in the past:

List of current medications: _____

Note: Clients using insurance or making claim for auto or work-related injuries, please complete second page of form.

I understand that Licensed Massage Practioners do not diagnose illness, disease, or other physical or mental disorders. I have stated all my known medican conditions and will inform the Massage Practioner of any changes in my physical health should it occur.

Signature: _____ Date: _____

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Insurance Information

Primary Insurance:

Company Name / Plan Name: _____ Phone #: _____

Company Address: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to you: ◯ Self ◯ Spouse ◯ Dependant ◯ Other

ID # (as shown on the card): _____ Group #: _____

Doctor's Name and Phone #: _____ Do you have referral? ◯ Y ◯ N

Injury related to: ◯ Work ◯ Auto Accident Date of Accident or Injury: _____

Claim #: _____ Insurance Adjuster: _____ Phone #: _____

Secondary Insurance (if applicable):

Company Name / Plan Name: _____ Phone #: _____

Company Address: _____

Subscriber's Name: _____ Date of Birth: _____

Relationship to you: ◯ Self ◯ Spouse ◯ Dependant ◯ Other

ID # (as shown on the card): _____ Group #: _____

Attorney Information (if applicable):

If you have an attorney working on this claim, please provide the following:

Attorney Name: _____ Phone #: _____

Attorney Address: _____

Is this a third party billing? ◯ Yes ◯ No

Additional Information:

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Release of Medical Records

My signature below authorizes the release of my medical records. This includes intake forms, chart notes, reports and billing statements that will be releases to healthcare providers, insurance case managers and attorneys for the purpose of processing claims. I will inform my practitioner immediately of any changes in my records or health information.

Signature: _____ Date: _____

Privacy Policy Act

At Smokey Point Massage Therapy, LLC we respect your privacy. We understand that health information is sensitive. We will not disclose your information to others unless you tell us to do so or unless the law authorizes or requires us to do so. Under privacy act laws, the health information we obtain is protected. Federal and State law requires us to use and disclose this health information for the purpose of treatment. State law requires us to obtain your authorization to disclose this information for payment purposes.

You, as our client, have the right to request further information regarding these laws. You may also request information regarding your personal health information. This includes any request asking us to restrict certain uses or disclosures. This request must be received in writing.

Signature: _____ Date: _____

Other Policies and Notes

I understand I need to cancel massages appointments with 24 hour notice. I will be charged a $30 fee if proper notice is not given. Exceptions are at the discretion of the practitioner.

I am responsible for all bills incurred during massage treatments. Payment is due the day of service unless I have work, auto or health insurance claim. Co-pays for health insurance are due the day of service. The practitioner will provide a billing service for these types of claims. I understand all bills are my responsibility.

Signature: _____ Date: _____