Kelly Conlin Bodywork // Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize Kelly Conlin, LMT to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

This authorization permits Kelly Conlin, LMT to use or disclose to Quality Medical Billing Service (QMBS) the following individually identifiable health information required for the processing of your insurance claim which may include pertinent healthcare information as requested by your insurance company. Patient confidentiality will be maintained to the fullest extent of the law.

This authorization will expire on _____.
{Expiration Date or Defined Event}.

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Kelly Conlin, LMT has acted in reliance upon this authorization. My written revocation must be submitted to Kelly Conlin, LMT.

Signed:_____ Date: _____
Signature of Patient or Legal Guardian

Relationship to Patient: _____

_____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian

(Over)

Kelly Conlin Bodywork // Agreement of Patient Financial Responsibility

Kelly Conlin Bodywork will bill your medical insurance company for services rendered. You are responsible for any fee or copay at the time of your appointment. Any charges within your insurance deductible will also be your responsibility to pay at the time of service. In addition, if your insurance does not pay for the services rendered, you will be held responsible for paying your balance within 30 days of receipt of an invoice from Kelly Conlin Bodywork. If you do not pay within 30 days of the date of service or invoice, you will be charged a $50 late fee and be subject to 1.5% monthly interest on any outstanding balance. Your insurance will not pay for these charges, nor will they pay for missed appointments.

I acknowledge and agree to the above policies, and to my financial responsibility for services rendered, should insurance not pay for them.

Patient Signature: _____ Date: _____

Print Name: _____

Kelly Conlin Bodywork // Intake Form

Today's date: _____

First name _____ Last name _____

Date of birth _____ Occupation: _____

Email address (reminder emails will be sent to this address) _____

Phone number (Cell/home/work?) _____ May we text you? Y / N

Home address _____ Apt. _____

City, state, zip code _____

Emergency contact name _____ Phone _____

How did you hear about us? _____

Hobbies, sports, fitness activities: _____

What brings you here today? _____

_____

What are your goals for your session? _____

_____

__ Bruise easily
__ Athlete's foot
__ Infectious skin condition
__ Hepatitis
__ Cancer
__ Fibromyalgia
__ Autoimmune disorder
__ Osteoarthritis
__ Rheumatoid arthritis
__ Recent injury or surgery
Explain: _____
__ Edema
__ Implants: _____
__ Artificial joints

Existing conditions:

__ Blood clots
__ High blood pressure
__ Low blood pressure
__ Pacemaker
__ Varicose veins
__ Congestive heart failure
__ Phlebitis
__ Heart attack
__ Lymphedema
__ Stroke
__ Heart disease
__ Vertigo
__ Thrombosis/Embolism
__ Osteoporosis

__ Headaches
__ Diabetes
__ Dizziness
__ Allergies: _____
__ Mental illness
__ Anaphylaxis
__ Epilepsy
__ Loss of or lowered sensation
__ Shingles
__ Multiple Sclerosis
__ Herniated disc
__ Back surgery
__ Stress

Any allergies relevant to massage? (Scents, nut oils, essential oils, etc.) _____

_____

Any other medical conditions not listed above? _____

_____

Please list your medications _____

_____

Any chance you could be pregnant? Y / N

Do you have any difficulty lying:

__ On your back
- __ in general
- __ for a certain amount of time
  how long? _____

__ On your belly
- __ in general
- __ for a certain amount of time
  how long? _____

__ On your side (L / R / B)
- __ in general
- __ for a certain amount of time
  how long? _____

Do you have pain/issues in:
(left/right/both/mid)

__ Feet L/R/B
__ Ankles L/R/B
__ Knees L/R/B
__ Hips L/R/B
__ Legs L/R/B
__ Low back L/R/B/M
__ Midback L/R/B/M
__ Upper back L/R/B/M
__ Neck L/R/B/M
__ Shoulders L/R/B
__ Elbows L/R/B
__ Hands L/R/B
__ Arms L/R/B

Sensations:

__ Burning
__ Numbness
__ Tingling
__ Stabbing
__ Radiating
__ Shooting
__ Deep ache
__ Dull ache
__ Weakness

Signature _____ Date: _____

Client waiver:

- I certify that the above information is true and accurate.
- I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.
- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapists's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.
- By signing this release, I hereby waive and release my therapist from any and all liability, past, present and future relating to massage therapy and bodywork.

Signature _____ Date: _____

Kelly Conlin Bodywork // Cancellation Policy

Kelly Conlin Bodywork appreciates that you chose our office for your massage and bodywork session. It is our absolute intention to provide top notch and personal care. In order to do that, the time that you scheduled is time set aside only for you. We understand that issues occur to cause lateness or the need to cancel or reschedule, and ask that you adhere to the following standards to help us run our practice smoothly and give you the best possible service.

Lateness:

Please call and let us know if you are running late. We will do our best to accommodate you. We generally can work with a 5 minute delay; however, at 10-15 minutes late or more, we will likely have to shorten your session by that amount of time. Full price will be charged for the actual scheduled time. In return, we will make sure we are on time, and if for some reason we are not, we will give you the time back or adjust the price of the session.

Cancellation and Rescheduling:

Because we set aside your scheduled time just for you, have other clients to consider, and need to maintain a smoothly running business, we find it necessary to charge for appointments that are canceled or rescheduled at the last minute.

If you need to cancel or reschedule your appointment, we ask that you give **24 hours notice. Anything less than that is considered a last minute cancellation or reschedule**. Text, voice, and email are all acceptable means of notice.

In the case of a last minute reschedule, your card on file will be automatically charged $45.00.

In the case of a last minute cancellation or no show, your card on file will be automatically charged the full price of the missed session. For insurance patients, the charge is $85.00.

If for some reason there is no card on file, the fee is due at your next session, or upon receipt of invoice.

In the unlikely case that we must cancel or reschedule your appointment with less than 24 hours notice, you will receive a session of equal length of your scheduled appointment, gratis.

Thank you for your understanding, and we look forward to serving you.

I certify that I have read and agree to the cancellation policy.

Signature: _____ Date: _____

Print name: _____