Limestone Therapeutic Massage

Massage Therapy for MVA and Workers' Compensation

Medical Information Intake

and Insurance Billing Information

First Name _____ Today's Date _____

Last Name _____ Gender: ☐ Male ☐ Female

Address _____ Date of Birth (D, M, Y) _____

City _____ State _____ Zipcode _____ Occupation _____

Preferred Form of Contact

☐ Mobile Phone _____

☐ Home Phone _____

☐ Work Phone _____

Emergency Contact

Name _____

Phone _____

Relationship _____

EMAIL:

Please take a moment and carefully read the following information. Signature is required where indicated.

Confidentiality Statement (HIPAA disclosure)
It is necessary that we notify every patient/client at Limestone Therapeutic Massage of our policy in regards to maintaining the privacy of your confidential information. There are three reasons in which we will disclose Protected Health Information (PHI) in regards to our patients/clients. The three reasons are Treatment, Payment and Operations. Operations will include calling to confirm appointments. Limestone Therapeutic Massage must obtain or receive written authorization to use or disclose a patients/clients PHI for any other purpose other than Treatment, Payment and Operations. We have taken every conceivable effort to protect your PHI and have had every employee and persons affiliated with Limestone Therapeutic Massage sign a confidentiality agreement to protect your PHI. Copies of our HIPAA policy is available at our reception desk.

I understand that:

- Specific medical conditions or specific symptoms may be contraindicated (should not be done) for massage/bodywork. Referral from my primary care provider may be required prior to services being provided. Because massage/bodywork is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Limestone Therapeutic Massage updated to any changes in my medical profile. I understand that there shall be no liability on the part of Limestone Therapeutic Massage or it's practitioners should I not disclose all previous existing or new injuries/surgeries/medications or any other possible contraindication. I understand that it is my responsibility to inform Limestone Therapeutic Massage of any changes in my health.
- The massage/bodywork I receive is provided for the basic purpose of relief from muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist, so that the pressure and/or strokes may be adjusted to my level of comfort.
- Any information I receive from any employee or massage therapist at Limestone Therapeutic Massage is educational in nature and is to be used at my own discretion.
- Massage/bodywork should not be used as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified specialist for any physical or mental ailment that I am aware of.
- Massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness and that nothing said in the course of my session should be construed as such.
- Any illicit or sexually suggested remarks or advances made by me will result in my therapist immediately terminating the session, and I will be personally liable for payment of the scheduled appointment which will not be billed to my insurance provider.

(INITIAL) We at Limestone Therapeutic Massage will accept insurance assignment in handling the billing to your open and billable personal injury or workers' compensation claim. However, in order to help ensure that your insurance company pays for the care you receive here, it is important that you adhere to the care program that your referring physician has prescribed. It is equally important that you arrive on time for all of your scheduled appointments. If you arrive 15 minutes late for your appointment, the treatment time will be shortened and a bill will be mailed to you for the portion that is not billable to insurance. If you are more than 25 minutes late, your appointment will be rescheduled and you will be responsible for payment of the missed appointment. Please understand that when treatments are scheduled in advance, the therapist is setting aside this time specifically for you on the day and time that you have chosen. Your insurance company will not and cannot be billed for late or missed appointments. We require a 24hr cancellation notice by telephone for all missed appointments. If (3) appointments are missed (emergencies considered), you may be dismissed from care and your file will be closed. All missed appointments will require full payment of that scheduled service ($80/2-units, $160/4-units). Appointments that are cancelled or rescheduled with less than 24hr notice require a 50% payment of the originally scheduled service and an invoice will be mailed to you on each occasion. Our acceptable payment methods are cash or credit card and payment is expected within 14 days from date of invoice.

Client Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

***Parental / Legal Guardian's Consent to treat a minor under the age of 18 years. (Senate Bill 114. Signed by Governor Markell on 8/6/2013.)**
A parent or legal guardian must be present when an LMT or CMT provides massage and/or bodywork services to a minor client. The minor's parent or legal guardian has the right to be present in the therapy room while the minor receives a massage and/or bodywork. (Senate Bill 114. DE. Law 24 Del.C.5318.)

Parent or Legal Guardian Signature: _____ **Date:** _____

Please print name of Parent or Legal Guardian: _____

Patient Name:

The following questions pertain to your HEALTH HISTORY, unrelated to your accident

Please check ☑ all conditions or symptoms you currently have or have had in the past:

☐ Anemia	☐ Bursitis	☐ Emphysema	☐ Jaw Pain/TMJ	☐ Stroke
☐ Appendicitis	☐ Breathing Difficulties	☐ Epilepsy	☐ Migraine Headaches	☐ Seizures
☐ Arthritis	☐ Bronchitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Tendonitis
☐ Asthma	☐ Cancer _____	☐ Hepatitis	☐ Osteoporosis	☐ Thyroid Problems
☐ Blood Clots	☐ Carpel Tunnel	☐ Hernia	☐ Pacemaker	☐ Tumors/Growths
☐ Low Blood Pressure	☐ Chemical Dependency	☐ Herniated Disk	☐ Parkinson's Disease	☐ Ulcer's
☐ High Blood Pressure	☐ Diabetes	☐ HIV/AIDS	☐ Pinched Nerve	☐ Varicose Veins
☐ Other (Please List)				

Have you ever applied and/or been approved for Social Security Disability? Yes No If yes, reason?_____

List past surgical history **Date/Year**

_____

_____

_____

List past injury history (falls, accidents, head, whiplash, broken bones) **Date/Year**

_____

_____

_____

Please list all medications and vitamins you may be taking for **HEALTH REASONS that are unrelated to your accident.**

Name the medication or vitamin	Reason for using this product?	Currently taking?	How often?
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	
		Yes No	

List allergies **Reaction and Symptoms**

_____

_____

_____

Exercise Habits. ☐ Daily ☐ ___ times a week ☐ Never	**Work Activity.** ☐ Sitting ☐ Standing ☐ Hard Labor	**Tobacco Use.** ☐ ___ a day ☐ Occasionally ☐ Never
Alcohol Consumption. ☐ ___ a day ☐ Occasionally ☐ Never	**Recreation Drug Use.** ☐ ___ a day ☐ Occasionally ☐ Never	**Stress Triggers.** ☐ Work ☐ Family ☐ _____

* Female clients please answer the following questions.

Are you pregnant? Yes No If yes, when is your due date? _____ If no, are you currently trying to conceive? Yes No

If you are pregnant, do you have your Dr's approval for massage treatments? Yes No

Dr. Name: _____ Phone _____

Workers' Compensation Intake Information

Complete this form if you have been in a job related injury and have an open claim

Patient Name_____

Date of Injury _____ Today's Date_____

Briefly describe the events that occurred just before and during your accident.

_____

_____

_____

What are your expected results in regards to your massage therapy treatments? (Pick all that apply)

☐ Increase of overall mobility	☐ Manage stress/anxiety	☐ Diminish neck spasms	☐ Reduce the need of pain medication
☐ Better range of motion in neck	☐ Reduce inflammation	☐ Diminish back spasms	☐ Return to pre accident health
☐ Pain reduction	☐ Regain muscle strength	☐ Regain muscle flexibility	☐ _____

The following questions pertain to your injuries and treatments you have received for this injury.

When did you first see a physician for this injury? ☐ Just after accident ☐The next day ☐ 2+ days later

Name the body parts which were injured in your accident. _____

Did you sustain bruises? ☐ Yes ☐ No If yes, where? _____ Any broken bones? ☐ Yes ☐ No If yes, where?_____

Any bleeding/lacerations? ☐ Yes ☐ No If yes, where? _____ Have you had any X-ray's or a MRI? ☐ Yes ☐ No

Have you been able to work since this injury? ☐ Yes ☐ No

Are your regular work activities restricted as a result of this injury? ☐ Yes ☐ No If yes, please explain_____

_____

Check or list any treatments or procedures you have received for your injury

☐ Hot Packs	☐ TENS Unit	☐ Cortisone Injections	☐ Surgery
☐ Ice Packs	☐ Strengthening Exercises	☐ Trigger Point Injections	*Type of surgery*
☐ Massage	☐ Physical Therapy	☐ Spinal fusions	_____
☐ Electrical Stimulation	☐ Traction/Gravity Inversion	☐ Acupuncture	_____
☐ Ultrasound	☐ Chiropractic	☐ Naturopathy	_____

Please list medications you have received for this injury

Name of medication	Reason for medication	Currently taking?	How often?
		YES NO	
		YES NO	
		YES NO	

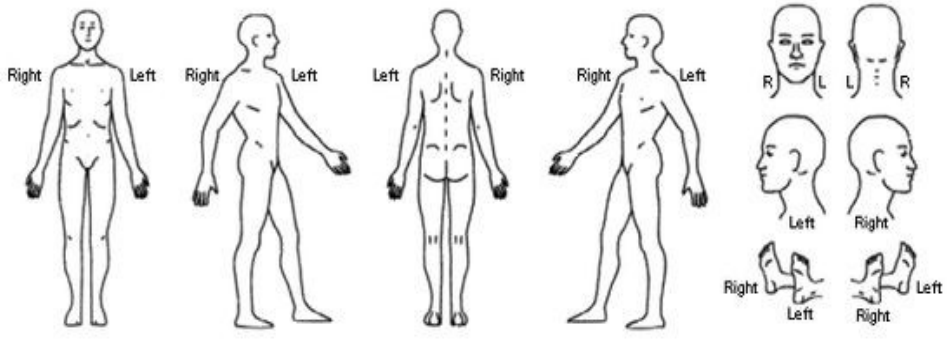
On a scale of 1-10 (1= No Pain, 10= Extreme Pain) how would you rate your **current level of pain** PLEASE CIRCLE

No Pain ⇐ 1 2 3 4 5 6 7 8 9 10 ⇒ Extreme Pain

The following diagram pertains to the pain (if any) that you have experienced SINCE the accident.

Use the letter key to show where you are experiencing problems:

A. Achy, Dull, Sore
B. Stiffness, Tightness
C. Sharp stabbing pain
D. Sharp shooting pain
E. Numbness, Tingling
F. Burning
G.Throbbing
H. Swelling
I. Snapping, Popping, Grinding
J. Other _____



Insurance Billing Information

Though I remain personally responsible for my bill, I prefer that Limestone Therapeutic Massage to send my bills to:

☐ Auto Accident PIP/MVA Claim ☐ Workers' Compensation Claim ☐ Other _____

Limestone Therapeutic Massage will bill your open claim on your behalf. In the event that your claim is closed, denied or benefits become exhausted, you must notify our billing office immediately and financial arrangements will be made available to you.

Auto Accident PIP/MVA Claim Claim Number_____

Insurance Company _____ Date of Accident _____

Insurance Address _____

Adjuster's Name _____ Phone _____ X_____

Adjuster's Email _____

PIP Benefit Limits $_____ PIP Benefits Remaining $_____

Referring Doctor _____ Phone _____

What diagnosis was given from your Dr. for treatment? _____

Notes: _____

Workers' Compensation Claim Claim Number_____

Insurance Company _____ Date of Injury _____

Insurance Address _____

Adjuster's Name _____ Phone _____ X_____

Adjuster's email _____

Body part(s) covered by this claim _____

Referring Doctor _____ Phone _____

What diagnosis was given from your Dr. for treatment? _____

Notes: _____

Attorney Information

Attorney's Name _____ Phone _____

Paralegal/Secretary _____ Phone _____

Office Address _____

Assignment of Benefits

I authorize _____ (insurance company) to pay Limestone Therapeutic Massage directly any benefits due me under this claim by medical payment, disability benefits or both. I understand and agree that only unpaid balances to include deductibles and co-payment not covered by this policy will be paid by me on the day services are rendered unless Limestone Therapeutic Massage agrees in writing to defer payment until the time of any settlement. Should payment be denied by any insurance carrier, I agree to pay any outstanding bill in full in 30 days of receipt of the bill and I further understand services will be discontinued until payment is in full. The above insurance billing information is complete and accurate to the best of my knowledge. By my signature, I clearly understand and agree to these policies and that I am ultimately responsible for any financial obligation of services rendered to me.

_____ _____

Patient Signature or Guardian if patient is a minor Date

Notice of Insurance Billing Policies

I understand that Limestone Therapeutic Massage will prepare and send appropriate Motor Vehicle Accidents (MVAs) or Workers' Compensation claim forms for services rendered on my behalf, as a courtesy. If payment is not made to Limestone Therapeutic Massage within 45 days of the date of service it will be my responsibility to pay. If a claim is denied, services will terminate and payment must be made in full by me within 30 days of receipt of the bill.

Limestone Therapeutic Massage reserves the right to add a $10 monthly statement fee on any account that has an unpaid balance. Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Accounts referred to a collections agency or attorney may be subject to a collection fee of 25%, which will be added to the balance due. Patient is responsible for all attorney fees.

_____ _____

Patient Signature or Guardian if patient is a minor Date

Limestone Therapeutic Massage

Irrevocable Agreement for Payment of Medical Service Costs

This agreement is entered into for and in consideration of services rendered by Limestone Therapeutic Massage and in consideration of agreement to provide medical services in connection with accident date of _____.

I, _____ hereby authorize and direct my attorney, _____ to pay directly to Limestone Therapeutic Massage any outstanding balance due and owing for such medical services rendered to me for my for my accident and to withhold such sums from my settlement, judgment, or verdict recovered in my favor as may be necessary to adequately pay said medical bills. I direct my attorney to contact Byron Hobson, LMT, or his representative at the time of settlement of my claim to notify them of the recovery and to obtain a settlement of my accounts. In addition, I agree that no distribution of monies will be made to me by my attorney or insurance company until such time as my undisputed medical bills and costs have been paid.

In the event that another attorney or law firm is substituted in the prosecution of my claim, the new attorney must honor this agreement.

I fully understand that I am directly and fully responsible to Limestone Therapeutic Massage for all outstanding medical bills for medical services rendered to me for the above mentioned matter. I further understand that such payment obligation is not contingent on the successful settlement, judgment, or verdict by which I may eventually recover monies and it continues to be my own obligation to pay in full if no monies are recovered in connection with my accident case or worker's compensation case.

_____ _____

Clients Signature Date

_____

Clients Name (printed)

The undersigned being of record for the above named client in connection with said accident case, does hereby agree to observe all the above terms and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect and pay in full the outstanding balance due to Limestone Therapeutic Massage arising from the above mentioned accident.

_____ _____

Attorney's Signature Date