Welcome To Wagner Family Chiropractic, S.C. -- Massage Intake Form

Client Information

Date_____

Patient_____

Address_____

_____
City State Zip

Sex: ❑ M ❑ F Age_____ Birthdate_____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned Certify that I (or my dependent) have insurance coverage with_____ and assign directly to Wagner Family Chiropractic, SC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Phone Numbers

Home (____)_____Cell (____)_____

Best time and place to reach you_____

Email_____

IN CASE OF EMERGENCY, CONTACT:

Name_____Relationship_____

Home Phone_____

Accident Information

Is condition due to an accident? ❑ Yes ❑ No Date____

Type of accident ❑ Auto ❑ Work ❑ Home ❑ Other

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker Comp. ❑ Other

Attorney Name (if applicable)_____

_____

Client Condition

When did your symptoms begin?_____

What treatment have you already received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Chiropractic Care ❑ None ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

How often do you have this pain?_____ Is it constant or does it come and go?_____

Does it interfere with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Recreation

Activities or movements that are painful to perform ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying Down

Name and Address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name_____ Name_____

Address_____ Address_____

Phone (____)_____ Phone (____)_____

Massage History

Have you ever received a professional massage? ❑ Yes ❑ No

Why did you come for our service? ❑ Relaxation ❑ Pain ❑ Therapy ❑ Other_____

What results would you like to acheive?_____

_____

Prioritize the areas of your body that you wish to be massaged. Please note any areas of your body that you **prefer not to be** massaged.

_____

Health History

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

❑ Anemia	❑ Cancer	❑ Hepatitis	❑ Multiple Sclerosis	❑ Sinus Problems
❑ Anorexia	❑ Chemical Dependency	❑ Hernia	❑ Osteoporosis	❑ Stroke
❑ Appendicitis	❑ Diabetes	❑ Herniated Disc	❑ Pacemaker	❑ Tendonitis
❑ Arthritis	❑ Emphysema	❑ Herpes	❑ Parkinson's Disease	❑ Thyroid Problems
❑ Asthma	❑ Epilepsy	❑ High Blood Pressure	❑ Pinched Nerve	❑ Tuberculosis
❑ Blood Clots	❑ Fibromyalgia	❑ HIV/AIDS	❑ Pneumonia	❑ Tumors, Growths
❑ Breathing Difficulty	❑ Fractures	❑ Jaw Pain/TMJ	❑ Polio	❑ Ulcers
❑ Bursitis	❑ Glaucoma	❑ Lymphedema	❑ Prosthesis	❑ Varicose Veins
❑ Bronchitis	❑ Head Injuries	❑ Migraine Headaches	❑ Rheumatoid Arthritis	❑ Whiplash
❑ Bulimia	❑ Heart Disease	❑ Mononucleosis	❑ Rheumatic Fever	❑ Other_____

Exercise

❑ None
❑ Moderate
❑ Daily
❑ Heavy
Type_____

Work Activity

❑ Sitting
❑ Standing
❑ Light Labor
❑ Heavy Labor

Lifestyle

❑ Smoking Packs/Week_____
❑ Alcohol Drinks/Week_____
❑ Coffee/Caffeine Drinks Cups/Day_____
❑ High Stress Level Reason_____

Are you pregnant? ❑ Yes ❑ No Due Date_____

Please list any medical conditions, surgeries, accidents, and bone, joint, nerve or muscle diseases or injuries not specified above.

_____ _____ _____ _____

Medications	Allergies	Vitamins/Herbs/Minerals
_____	_____	_____
_____	_____	_____

Authorization

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that is my responsibility to inform my healthcare provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis, or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe, or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

_____ _____
Signature of Patient, Parent, Guardian or personal Representative Date

_____ _____
Please Print Name of Patient, Parent, Guardian or personal Representative Date

Wagner Family Chiropractic, S.C.

N110 Brux Road
Appleton, WI 54915
920-968-0464

www.wagnerchiropractic.net

INFORMED CONSENT TO TREATMENT AND RESPONSIBILITY AGREEMENT

Please read each section carefully. You will be furnished with a copy of this form for your own records.

Please print your name: _____

I, the undersigned, do hereby request and consent to the performance of chiropractic treatment and related physical therapy procedures upon the above-named patient (my dependent or myself). I wish to rely on the chiropractor to exercise judgment for my best interest during the course of treatment. I will inform the chiropractor or certified assistant who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. Although adverse events are extremely rare with chiropractic I understand that with any treatment there are risks. These risks include, but are not limited to fracture, stroke, and even death. I intend this consent to cover the entire course of treatment.

I understand payment is expected at the time of the visit. Any other arrangements, including direct insurance billing, payment plan or deferral, must be made in writing through the front desk. Verbal agreements are not acceptable. Monthly statements will include a $5.00 statement fee on all balances not paid within 30 days.

I realize a notice of 24 hours is encouraged for canceled appointments. I understand that my time slot is only for me and that by missing an appointment without canceling means that someone in need is unable to be seen. Therefore, canceling as early as possible is greatly appreciated to allow others my time slot. (Please call 920-968-0464 to cancel appointments.)

I hereby authorize the release of my medical records and other information necessary to process insurance claims.

I clearly understand and agree that all services rendered to me or to my dependent, the above-named patient, are charged directly to me and that I am personally responsible for payment. I understand that even if I suspend or terminate my treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____

Signature of Individual/Legal Representative* Date

_____

Relationship to Patient

*Attorney-In-Fact, Guardian, Parent if a minor

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PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:
    a) A postcard mailed to me at the address provided by me; and
    b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for *seven years*. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Signature of Individual/Legal Representative* Date

_____
Relationship to Patient

*Attorney-In-Fact, Guardian, Parent if a minor