elemental medicine
Chiropractic, Acupuncture & Massage

2915 SE Belmont St., # 1
Portland, OR 97214
503.505.9677
elementalmedicinepdx.com

Client Health Information Sheet for Therapeutic Massage

Legal Name: _____ Date: _____

Preferred Name: _____ Gender: Male / Female / Other

Address: _____ City: _____ State: _____ Zip:_____

Date of birth: _____ Phone: _____

Email address: _____ How did you hear about us?_____

In case of emergency, please notify: _____

Phone: _____ Relationship: _____

Have you ever received massage before? Yes / No If so, when?: _____

What is your major complaint or condition you want to improve?_____

What are your intentions or expectations for this visit? _____

_____

Present symptoms: _____

_____

What activities aggravate the condition? _____

What provides relief? _____

Does this condition interfere with: Work? Yes / No Sleep? Yes / No Daily Routine? Yes / No

Please Explain: _____

List any medications (including aspirin) and nutritional supplements you are taking:

_____

_____

Are you currently under medical treatment? Yes / No If yes, for what condition(s)?

_____

Signature of Patient or Guardian_____ Date_____

Print Patient Name _____

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Describe exercise/activities you do (include frequency): _____

_____

Please list any accidents or operations (date and description): _____

_____

C = Current **P = Past**

___ Bone or joint disease	___ Tendonitis/Bursitis	___ Arthritis/Gout
___ Jaw Pain (TMJ)	___ Lupus	___ Spinal Problems
___ Migraines/Headaches	___ Osteoporosis	___ Heart Condition
___ Phlebitis/Varicose Veins	___ Blood Clots	___ High/Low Blood Pressure
___ Lymphedema	___ Thrombosis/Embolism	___ Asthma
___ Emphysema	___ Allergies, Specify:_____	
___ Sinus Problems	___ Shingles	___Numbness/Tingling
___ Pinched Nerve	___ Paralysis	___ Multiple Sclerosis
___ Parkinson's Disease	___ Pregnant	___ Menstrual Problems
___ Prostate	___ Skin Allergies	___ Rashes
___ Cosmetic Surgery	___ Athlete's Foot	___ Herpes/Cold Sores
___ Irritable Bowel Syndrome	___ Bladder/Kidney	___ Colitis
___ Crohn's Disease	___ Ulcers	___ Anxiety/Stress Syndrome
___ Depression	___ Cancer/Tumors	___ Diabetes
___ Drug/Alcohol/Tobacco Use	___ Contact Lenses	___ Dentures
___ Hearing Aids	___ Any other medical condition(s) not listed:_____	

_____

Please list any additional comments regarding your health and well-being: _____

_____

_____

Signature of Patient or Guardian_____ Date_____

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Acknowledgement and Understanding of Financial Policy

Please initial each item below. If you have questions, do not hesitate to ask.

_____ I understand that full payment is due at time services are rendered unless prior arrangements have been made.

_____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by the providers at Elemental Medicine.

_____ After verification of insurance benefits, Elemental Medicine will accept payment directly from your carrier. **Your insurance is an agreement between you and your insurance company. Elemental Medicine does not promise that your insurance company will pay all charges relative to your care even after verification has been made. Therefore, all charges disputed by your carrier will be your personal responsibility, to be paid in full by you no more than 60 days from date of notification from your carrier, via Square Invoice emailed by Elemental Medicine.**

_____ I agree to pay all Uncovered Services at the time of the visit (i.e. deductible, co-payment etc.)

_____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

_____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, Private insurance, and all other health plans to Elemental Medicine, 2915 SE Belmont St, Suite 1, Portland, OR 97214.

_____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

_____ I understand and agree that **I will be charged $50** in the event that I neglect to provide **24 hours notice of cancellation** if I am unable to make my scheduled appointment time. I also understand this fee will *not* be covered by my insurance, if any is available.

_____ _____
Patient Name / Patient Signature Date

_____ _____
Guarantor Signature Relationship to Patient

Authorization to Treat a Minor

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ ____/_____/_____ _____
Patient's Full Name Date of Birth Age

This authorization will be effective as of _____ and expires on _____

Signature of Patient or Guardian_____ Date_____

Print Patient Name _____

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Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We care about our patient's privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this notice of our privacy practices. You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services.

Healthcare Operations
We may use and disclose your information for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs and getting the accreditation, certificates, licenses and credentials needed to serve you. We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, and law enforcement. You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization

Your Rights
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. You have the right to request a restriction of your protected health information. The physician is not required to agree to a restriction that you request. You have the right to request that we communicate with you about your medical information by different means or to a different location. This request must be made in writing. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may request a copy of this notice.

Questions or Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filing a complaint.*

By signing below, I acknowledge that I have read, understand and accept the terms of this document.

Signature of Patient or Guardian_____ Date_____

Print Patient Name _____