SYNERGY WELLNESS CENTER

Wellness Becomes You

Massage Intake Form

Name_____ Date of Birth_____ Age_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

SSN_____ Gender_____ Marital Status_____ Spouse Name_____ # of Kids_____

Occupation_____ Employer_____ Work Phone_____

Name of Nearest Relative (emergency contact) _____ Phone_____

Who referred you to our office? _____

Is your visit due to and injury (car accident/on the job)? Yes No (If yes, please get an injury report from the front desk)

Briefly describe your symptoms_____

Activities of daily living that are affected_____

_____

Are you currently taking any medications and/or supplements? (If yes, please list and reason) _____

_____

List any surgeries with dates_____

Height_____ Weight_____ Hobbies/Sports_____

PLEASE CHECK BOX OF ANY SYMPTOMS THAT YOU HAVE OR HAD IN THE LAST 3 MONTHS

- ☐ Headache
- ☐ Neck Pain
- ☐ Stiff Neck
- ☐ Sleeping problems
- ☐ Back Pain
- ☐ Chest Pain
- ☐ Dizziness
- ☐ Allergies
- ☐ Pins & needles in hands/arms
- ☐ Pins & needles in fees/legs
- ☐ Numb fingers
- ☐ Numb toes
- ☐ Digestive problems
- ☐ Constipation
- ☐ Asthma
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Ears ringing
- ☐ Loss of balance
- ☐ Fainting
- ☐ Head heavy
- ☐ Cold hands/feet
- ☐ Sinus trouble
- ☐ Cancer

Female Only

- ☐ Painful menstruation
- ☐ Irregular cycle
- ☐ Breast problems
- ☐ Menopause

Are you pregnant?

☐ Yes ☐ No ☐ Not sure

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare and necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. It is my understanding that my credit may be checked if Synergy Wellness Center extends credit to me and I understand that if I suspend or terminate my care, fees for professional services rendered to me will be immediately due and paid unless other arrangements are made I hereby authorize the doctors of Synergy Wellness Center and whomever they may designate as their assistants to administer treatments as they so deem necessary and also authorize the release of any information acquired in the course of examination of treatment. I certify that the above information is true and correct.

Signature_____ Date_____

Synergy Wellness Center

Wellness Becomes You

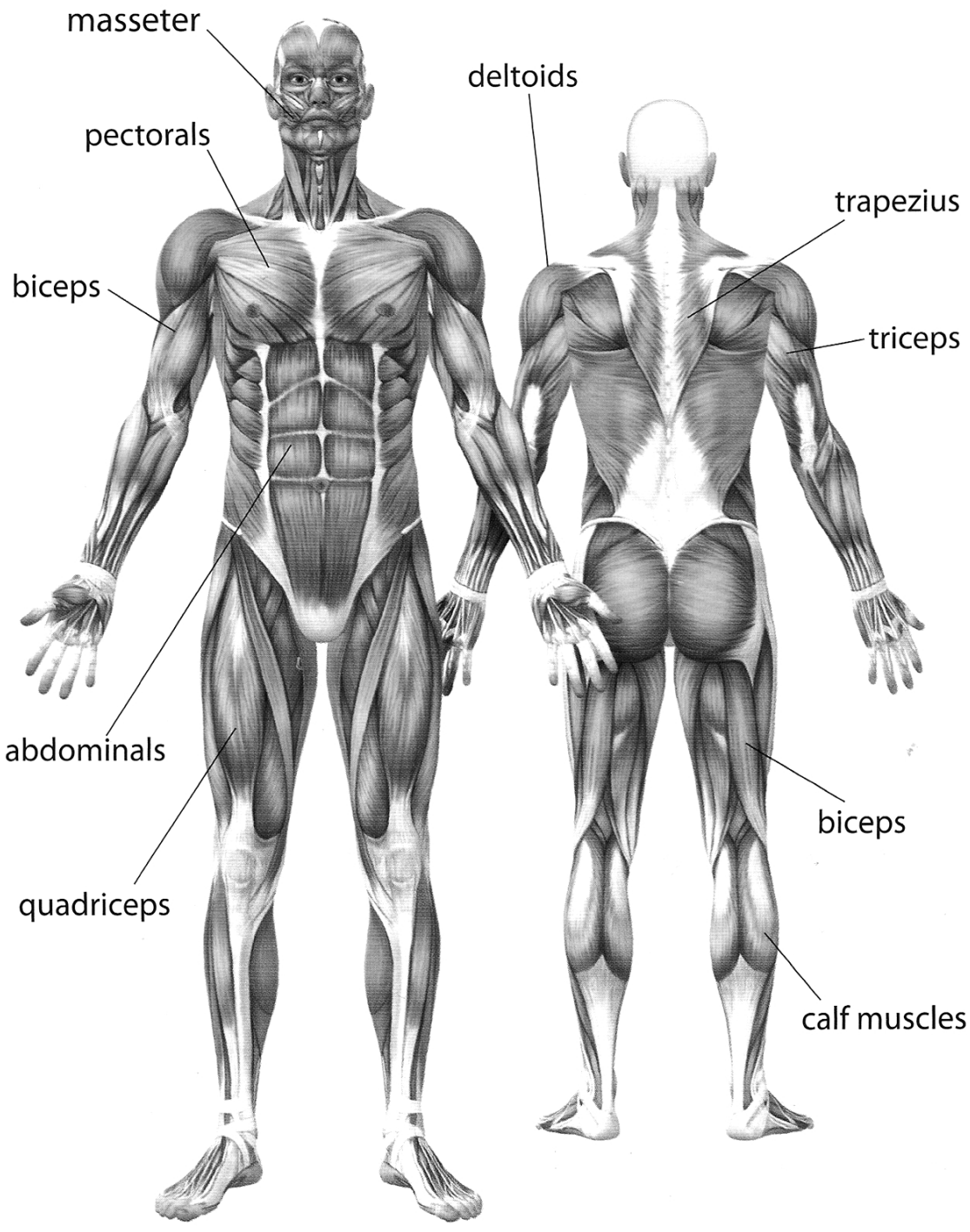
Personal Pain Map

Patient Name: _____ Date: _____

Use the following scale to indicate your pain level: (minor) 1 to 10 (severe)

Mark the areas on your body where you feel the described sensations. Include all affected areas.

A – Ache **B** – Burning **N** – Numbness **P** – Pins & Needles **S** – Stabbing



Synergy Wellness Center

Wellness Becomes You

Massage Questionnaire

Name: _____ DOB_____

1. What is your level of pain? 1 2 3 4 5 6 7 8 9 10 (10 being severe)
   Please indicate the most painful area(s).

2. Is this your first massage experience? Yes No

   a. If no, what other styles of massage have you received?

3. Is your pain level affected by stress?

4. What is the level of your stress? 1 2 3 4 5 6 7 8 9 10 (10 being severe)

5. What is your home regimen to relieve pain, tension, and/or stress?

6. Are there any health concerns that you are under the care of a medical doctor for that the massage therapist should know about? Example, diabetes, high blood pressure

7. Are there specific areas that you would like the massage therapist to focus on?

8. Are there specific areas that you would like the massage therapist to avoid?

I have informed the practitioner of all medical concerns and medical conditions. I do not hole the practitioner and/or the employees of Synergy Wellness Center liable for any information that I have not indicated regarding my medical concerns or conditions. _____ (Please initial)

Signature_____ Date_____

SYNERGY WELLNESS CENTER

Wellness Becomes You

Massage Appointment Policy

Massage Therapy greatly influences the circulatory system and can exacerbate illness. In the case of an illness please reschedule your massage therapy appointment for your health as well as the health of the therapist. If you are presenting with illness symptoms we have the right to refuse service to anyone at the therapists discretion.

Our office requires at least 24-hour notice if you are unable to keep your massage appointment. If less than 24-hour notice if given, or you miss your appointment without calling us, you will be charged missed appointment fee of $45 as this time has been reserved for you by the massage therapist. This fee is not covered by insurance and is your responsibility to pay immediately.

_____ (Please initial)

Our appointments are scheduled for specific lengths of time to ensure adequate service to our patients. Tardiness to appointments, in excess of 15 minutes, has an adverse impact on patient care. Patients who come late to an appointment will have their appointments canceled and will be charged a missed appointment fee of $45.

_____ (Please initial)

We understand that emergencies occur, and in special circumstances this fee may be waived.

I have read, understand, and agree to the above statement.

_____

Print name

_____ _____

Signature Date

SYNERGY WELLNESS CENTER

Wellness Becomes You

Medical Necessity Review Policy

Insurance plans deemed Massage Therapy as limited to Medical Necessity do not guarantee payment.

Regence defines medical necessity as "health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating illness, injury, disease or its symptoms, and that are:

a. In accordance with generally accepted standards of medical practice;

b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c. Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease."

If treatment is denied for lack of medical necessity you are responsible for the denied charges totally $70 per visit. Synergy Wellness will submit documentation when requested by the insurance agencies. It it your responsibility to follow program of care.

I have read, understand, and agree to the above statement.

_____

Print name

_____ _____

Signature Date

SYNERGY WELLNESS CENTER

Wellness Becomes You

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.

Synergy Wellness Center is required by law to maintain the privacy and confidentiality of your Protected Health Information (PHI) and to provide our patients with notice of our legal duties and privacy practices with respect to your Protected Health Information (PHI).

Disclosure of your Health Care Information:

Treatment
We may disclose your healthcare information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations (example):

"On occasion, it may be necessary to seek consultation regarding your treatment from other healthcare providers associated with Synergy Wellness Center."

"It is our policy to provide a substitute healthcare provider, authorized by Synergy Wellness Center to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation."

Due to the nature of Synergy Wellness Center's open adjustment areas; others may overhear conversations between the doctor and patient although every effort will be made to avoid loss of confidentiality. At any time, you may request a private consultation with the doctor.

Payment
We may disclose your PHI to your insurance provider for the purpose of payment or healthcare operations (example):

"As a courtesy to our patients, we will submit an itemized statement to your insurance carrier for the purpose of payment to Synergy Wellness Center for healthcare services rendered. If you pay for your healthcare services personally, we will, as a courtesy to you, provide and itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information including diagnosis, date of injury or condition, and codes which may describe the healthcare services received."

Worker's Compensation
We may disclose your health information as necessary to comply with State Worker's Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition in the event of an emergency or your death.

Public Health
As required by law, we may disclose your health information to public health authorities for the purpose related to: preventing or controlling disease, injury disability, reporting child abuse or neglect, reporting domestic violence, report to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infectious exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement
We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donation
We may disclose your health information to researchers conducting research that has been approved by the Institutional Review Board.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner, and government benefits purposes.

Marketing
We may contact you for marketing purposes or fundraising purposes, as described below:

"It is our practice to participate in charitable events to raise awareness, food donations, etc. During these times, we may send you a letter, post card or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Synergy Wellness Center sponsored fundraising or marketing events."

Change of Ownership
In the event that Synergy Wellness Center is sold or merged with another organization, your health information will become property of the new owner.

Your Health Information Rights

9. You have the right to request restriction on certain uses and discloses of your health information. Please be advised, however, that Synergy Wellness Center is not required to agree to the restrictions you request.
10. You have the right to have your health information received or communicated through alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
11. You have the right to inspect and receive a copy of your health information.
12. You have the right to request that Synergy Wellness Center amend your PHI. Please be advised, however, that Synergy Wellness Center is not required to agree to amend your PHI. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can dispute the denial.
13. You have the right to receive an accounting of disclosures of your PHI made by Synergy Wellness Center.
14. You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to the Notice of Privacy Practices
Synergy Wellness Center reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all the information that it maintains. Until such an amendment is made, Synergy Wellness Center is required by law to comply with this Notice. Any questions about this notice or if you want more information about your privacy rights, please contact the Office Manager by calling 425-357-1105. If he/she is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

Complaints
Complaints about your privacy rights or how Synergy Wellness Center has handled your health information should be directed to the Office Manager by calling 425-357-1105. If he/she is not available, you may make an appointment for a personal conference in person or by telephone within two (2) working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave SW
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of August 15, 2012.

SYNERGY WELLNESS CENTER

Wellness Becomes You

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understand the Notice.

_____ _____

Print Patient Name Date

_____

Patient/Parent Signature

SYNERGY WELLNESS CENTER

Wellness Becomes You

Consent to Leave Messages
Consent to leave messages/share information with family/friends

I understand that my healthcare information at Synergy Wellness Center is protected and I have received a copy of their Notice of Privacy Practices.

In order for Synergy Wellness Center to leave detailed messages on my voicemail or answering machine, I need to give permission to Synergy Wellness Center.

Consent to Leave Messages (please check box)

☐ Yes ☐ No

I consent to information regarding my (or my child's (under the age of 18)) test results or detailed appointment reminders/instructions to be left on my voicemail or answering machine.

Consent to Share Information with Family and/or Friends (please check box)

☐ Yes ☐ No

I wish family members and friends to have access to my healthcare information. The name(s) listed below are family members or friends whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and his/her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my Protected Health Information will be provided without my signature on a Medical Records Release form.

NAME	RELATIONSHIP
1. _____	_____
2. _____	_____
3. _____	_____

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Parent Signature Date

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up-to-date, as I recognize that relationships and friendships may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my Protected Health Information and cannot cancel actions taken or disclosures made while the designation is in effect.

15224 Main Street Suite 303 | Mill Creek, WA 98012 | Phone: 425-357-1105 | Fax: 425-379-9771
www.synergymillcreek.com