



Confidential Health History Form

Massage Therapy

Name: Home #: Cell #:

Address: Email:

City: State: Zip:

Date of Birth: Sex: Female Male Marital Status:

Emergency Contact: Phone #:

Occupation: Employer/School: Work #:

Have you previously received massage therapy? Allergies to scents/oils?

Name and # of other healthcare practioners you are presently seeing and their speciality:

Do we have your permission to consult with them as necessary?

Briefly describe your primary health concern(s) or complaint(s):

Please check if you have or have had in the past any of the following:

- Diabetes, High Blood Pressure, Cancer, Varicose Veins, HIV/Aids, Heart Problems, Arthritis, Currently Pregnant?, Other (note below)

Indicate Level of Consumption

Table with 4 columns: None, Light, Moderate, Heavy. Rows include Exercise, Salt, Sugar, Caffeine, Tobacco, Alcohol.

Please provide additional information containing those items checked or any other specific health-related conditions, including injuries, you currently have or have had in the past:

Empty text box for additional information.

List of current medications:

Note: Clients using insurance or making claim for auto or work-related injuries, please complete second page of form.

I am aware of the benefits and risks and give my consent for massage. I understand that Licensed Massage Therapists do not diagnose illness, disease or other physical or mental disorders. I have stated all known medical conditions and current medications and will inform the Massage Therapist of any changes that should occur.

Signature: Date:



Smokey Point Massage Therapy, LLC  
16404 Smokey Point Blvd., Suite 307  
Arlington, WA 98223

360-653-0950

## Insurance Information

### Primary Insurance:

Company Name / Plan Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Company Address: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to you:  Self  Spouse  Dependant  Other  
ID # (as shown on the card): \_\_\_\_\_ Group #: \_\_\_\_\_  
Doctor's Name and Phone #: \_\_\_\_\_ Do you have referral?  Y  N  
Injury related to:  Work  Auto Accident Date of Accident or Injury: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Insurance Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_\_

### Secondary Insurance (if applicable):

Company Name / Plan Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Company Address: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Relationship to you:  Self  Spouse  Dependant  Other  
ID # (as shown on the card): \_\_\_\_\_ Group #: \_\_\_\_\_

### Attorney Information (if applicable):

If you have an attorney working on this claim, please provide the following:

Attorney Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Attorney Address: \_\_\_\_\_  
Is this a third party billing?  Yes  No

Additional  
Information:



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## Release of Medical Records

My signature below authorizes the release of my medical records. This includes intake forms, chart notes, reports and billing statements that will be released to healthcare providers, insurance case managers and attorneys for the purpose of processing claims. I will inform my practitioner immediately of any changes in my records or health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Privacy Policy Act

Smokey Point Massage Therapy, LLC and all practitioners associated with and working within respect your privacy. We understand that health information is sensitive. We will not disclose your information unless you request or the law authorizes or requires us to do so. Under privacy act laws, the health information we obtain is protected. Federal and State law requires us to use and disclose this health information for the purpose of treatment. State law requires us to obtain your authorization to disclose this information for payment purposes.

You, as our client, have the right to request further information regarding these laws. You may also request information regarding your personal health information. This includes any request asking us to restrict certain uses or disclosures. This request must be received in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Other Policies and Notes

I understand I need to cancel massages appointments with 24 hour notice. I will be charged a \$30 fee if proper notice is not given. Exceptions are at the discretion of the practitioner.

I am responsible for all bills incurred during massage treatments. Payment is due the day of service unless I have work, auto or health insurance claim. Co-pays for health insurance are due the day of service. The practitioner will provide a billing service for these types of claims. I understand all bills are my responsibility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_