BALANCE PHYSICAL THERAPY INC.
730 NW Gilman Blvd
Suite C-108
Issaquah, WA 98027
Ph: (425) 391-6794
Fx: (425) 391-1525
www.balancept.org

MASSAGE INTAKE FORM

PATIENT INFORMATION (Please Print)

Patient's Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would you like to receive email reminders? ☐ Yes ☐No Email Address: _____

Gender: _____ Date of Birth: _____

Employer Name:_____ Job Title/ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship:_____

Health Background:

How do you rate your overall health? _____

Accidents, injuries and/or surgeries in the last two years? Please list: _____

Are you pregnant? If yes, what is your due date: _____

Do you have any allergies and/or skin sensitivities? _____

Are you allergic to nuts or nut products? _____

Is there any additional medical issue we should know about? _____

If you have an issue you do not wish to state on this form, please discuss it with your therapist.

CONSENT FOR CARE:

Please read carefully and sign prior to treatment. If a copy of this release is desired, one will be provided for you.

LEGAL INFORMATION: BY SIGNING BELOW, I AGREE THAT I HAVE READ AND UNDERSTAND THE FOLLOWING - I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all known medical conditions and will keep the therapist updated as to any changes in my medical condition going forward. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations, draping or environment may be adjusted to my level of comfort. CLIENT BEHAVIOR - Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.

I understand that payment is due at time of service and that Balance Physical Therapy & Wellness cannot bill my insurance company for these services. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by BALANCE PHYSICAL THERAPY INC, PS, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Should any provision or portion of this Agreement be held unlawful or unenforceable, the balance of this Agreement shall be nonetheless in all respects remain binding and effective and shall be construed to be in full force and effect to the extent lawfully permissible. A copy, facsimile, or scan of this document is considered as valid as, and with the same force as, the original document.

Patient, Parent, or Guardian Signature: _____ Date: _____

Printed Name: _____

Relationship to patient: _____ Witness: _____

CANCELLATION POLICY

In order to best serve our patients and clients, it is necessary to give at least a 24 hour notice of cancellation for any scheduled massage therapy appointments with BALANCE PHYSICAL THERAPY & WELLNESS INC. A **$60 nonrefundable charge** for one-hour appointment, a **$90 nonrefundable** charge for 90 minutes appointment, and a **$120 nonrefundable** charge for two-hour appointments will be billed to you for any appointments that are missed and not cancelled at least 24 hours prior to the appointment. This applies to late cancellations and no shows. We understand that emergencies and illness do occur that are out of your control, and BALANCE PHYSICAL THERAPY & WELLNESS reserves the right to waive cancellation charges.

I agree to the above cancellation policy: _____ Date: _____

Privacy Practices - HIPAA

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described above, talk to us. Tell us what you want us to do, and we will follow your instructions.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information
- We will let you now promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Please let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**

Changes to the terms of this notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website – www.balancept.org.

Effective 01/01/2022 - This Notice of Privacy Practices applies to the following organizations:

Balance Physical Therapy Inc., P.S. – a Washington State Corporation

Records Agent: Kira Leek, PT, CEO 425-391-6794 phone, kira@balancept.org

I Acknowledge receipt of Balance Physical Therapy's Privacy Practices.

Signature: _____ Date: _____

Print Name: _____

Additional Requests: _____