EAGLE TRACE
SPINE & SPORT
NECK • BACK • INJURY

Welcome! Please complete this form completely and to the best of your ability. If you need assistance please ask the front desk person. Thank you.

# MASSAGE INFORMATION

## PERSONAL INFORMATION

Patient name _____ Date _____

Date of birth _____ Age ____ Sex M ☐ F ☐ E-mail _____

Address _____ City _____ State _____ Zip _____

Mobile phone #_____ Home phone #_____ Work phone #_____

Emergency contact _____ Relationship _____ Phone _____

## WELLNESS INFORMATION

Have you ever had a professional massage or bodywork? **Yes** ☐ **No** ☐ If so, when? _____

Have you received chiropractic care? **Yes** ☐ **No** ☐ Are you currently under chiropractic care? **Yes** ☐ **No** ☐

Do you take time to relax? **Yes** ☐ **No** ☐ Do you feel you are under stress? **Yes** ☐ **No** ☐

Are you currently physically active? **Yes** ☐ **No** ☐ If so, what activities & how often? _____

What goals/benefits do you wish to achieve from massage therapy? _____

## INJURY HISTORY

Auto Accident/When:___/_____ Work Injury/When:___/_____ Fall/When:___/_____ Sports Injury/When:___/_____

Describe any injury/conditions: _____

How long has this condition existed? _____ Have you had this condition in the past? _____

## MEDICAL INFORMATION

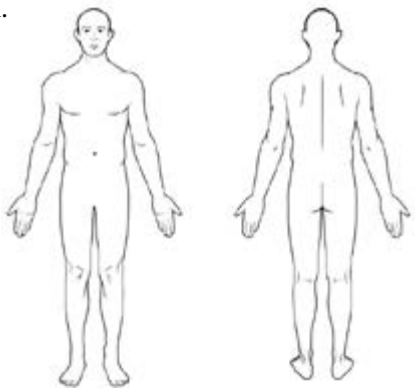
Are you currently taking medication? **Yes** ☐ **No** ☐ Please list: _____

Do you have any allergies? **Yes** ☐ **No** ☐ Please list: _____

Are you currently under the care of a physician, physical therapist, or psychologist? **Yes** ☐ **No** ☐ If so, why? _____

Check all conditions that apply and mark the areas you would like address on the human diagram.

| | | | |
|---|---|---|---|
| ☐ **Acne** | ☐ **Bronchitis** | ☐ **Fatigue** | ☐ **Liver Disorder** |
| ☐ **AIDS/HIV** | ☐ **Burns** | ☐ **Fractures** | ☐ **Lung Disease** |
| ☐ **Anemia** | ☐ **Cancer/Tumors** | ☐ **Headaches** | ☐ **Nervousness** |
| ☐ **Arteriosclerosis** | ☐ **Circulatory Issues** | ☐ **Hernia** | ☐ **Paralysis** |
| ☐ **Arthritis** | ☐ **Constipation** | ☐ **Herpes** | ☐ **Plates/Screws** |
| ☐ **Asthma** | ☐ **Cuts/Sores** | ☐ **High Blood Pressure** | ☐ **Pregnant** |
| ☐ **Athlete's Foot** | ☐ **Diabetes** | ☐ **High Cholesterol** | ☐ **Rash** |
| ☐ **Back Pain** | ☐ **Diarrhea** | ☐ **Insomnia** | ☐ **Sinusitis** |
| ☐ **Blood Clots** | ☐ **Dizziness** | ☐ **Joint Disease** | ☐ **Skin Problems** |
| ☐ **Broken Bones** | ☐ **Epilepsy** | ☐ **Kidney Disease** | ☐ **Spinal Problems** |



How did you find out about us? _____

EAGLE TRACE
SPINE & SPORT
NECK • BACK • INJURY

Welcome! Please complete this form completely and to the best of your ability. If you need assistance please ask the front desk person. Thank you.

# PRIVACY AND INFORMED CONSENT

## PRIVACY POLICY — HIPAA NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and specifically its Privacy Rule, I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider that may be involved in my treatment directly or indirectly.
- Obtain payment or reimbursement from health coverage programs or others.
- Conduct normal healthcare business operation including routine aspects of operating a health related practice or business.

The privacy officer for Eagle Trace Spine may be contacted by mail by writing to 12002 County Road 11, Burnsville, MN 55337

## INFORMED CONSENT — MASSAGE

I understand that a massage therapist provides the massage/bodywork I receive for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session , I will immediately inform the practitioner so the pressure and/or strokes will be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the session should be construed as such. Because message/bodywork should no be performed under certain medical conditions, I affirm that I have stated all known conditions and answered all questions honestly. I agree to keep the practitioner undated as to any changes in my medical profile and understand there shall be no liability on the practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. Lastly, I authorize instructor observation and demonstration of techniques if so warranted.

## APPOINTMENT POLICIES — MASSAGE

- **Cancellation Policy:** If you cannot make your appointment we ask you please contact our office 24 in advance to cancel. If your appointment is not canceled 24 hours in advance it will be considered a 'No Show' and you will be subject to our 'No Show' policy.
- **No Show Policy:** If you fail to cancel your appointment according to the cancellation policy you are considered a 'No Show' and will be unable to schedule you next appointment without providing payment in advance. If you fail to redeem this appointment time of fail to cancel according to the 'Cancellation Policy' you will surrender your payment for this appointment. The 'No Show' fee is $40 for every occurrence.
- **Refusal of Service Policy:** We reserve the right to refuse to provide services to any person at anytime. Should you be denied service, you will be reimbursed for any unused services that have been paid in advance.

Consent for treatment of a minor. I authorize an Eagle Trace Spine and Sport certified massage therapist to administer massage, bodywork or somatic therapy techniques to my child or dependent as they deem necessary.

Name (please print)_____

**Patient/Guardian Signature** _____ **Date**_____

EAGLE TRACE
SPINE & SPORT
NECK • BACK • INJURY

This is a summary of our clinic policies. We believe that a clear definitions allow us both to concentrate on the most important issue; regaining and maintaining your health. We are happy to answer any questions you have about your account.

# OFFICE POLICY

## PAYMENT POLICY FOR PATIENTS WITH INSURANCE

Eagle Trace Spine and Sport will file your insurance claim for you, and will attempt to verify coverage of services to be performed. We will review this information with you and explain what services (if any) are not covered that you will be responsible for. You are responsible for the balance on your account for any professional services rendered if you insurance denies coverage. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed at 10% interest charge. Payment plans are available,but you must contact our office to setup these plans. Additional notes about insurance coverage:

- Copays are due at the time of service
- You may be responsible for a Deductible Amount. This amount is deemed 'Patient Responsibility.' Our office will bill you for this amount following our offices receipt of an 'Explanation of Benefits' (EOB) from your insurance company.
- You may be responsible for the co-insurance amount (% responsibility). Our office will bill you for this amount following our offices receipt of an Explanation of Benefits (EOB) from your insurance company.
- You may choose to make payment in advance of receiving a bill from any amount considered patient responsibility.

## PAYMENT POLICY FOR PATIENTS WITHOUT INSURANCE

You have the option of paying in full on the date of service, paying in advance for your services or receiving a bill from our office. Discounts apply for payment in advance and payment made on the same day. You are responsible for the balance on your account for any services rendered. Any balance billed from our office deemed 'Patient Responsibility' exceeding 90 days past due will be assessed a 10% interest charge.

## APPOINTMENT POLICIES — CHIROPRACTIC

In order for us to better serve all patients, please call if you will be late or unable to keep your scheduled appointment.

## APPOINTMENT POLICIES — MASSAGE

- **Cancellation Policy**: If you cannot make your appointment we ask you to please contact our office 24 hours in advance to cancel. If your appointment is not canceled 24 hours in advance it will be considered a 'No Show' and subject to our 'No Show' policy.
- **No Show Policy:** If you fail to cancel your appointment according to the cancellation policy you are considered a 'No Show' and will be unable to schedule your next appointment without providing payment in advance. If you fail to cancel this appointment according to the 'Cancellation Policy' you will surrender your payment for this appointment. The 'No Show' fee is $40 for every occurrence.
- **Refusal of Service Policy**: We reserve the right to refuse to provide services to any person at anytime. Should you be denied service, you will be reimbursed for any unused services that have been paid in advance.

By signing, I acknowledge having received and read the above 'Office Policy.' I hereby agree to the terms and conditions outlined.

Patient Name (please print) _____

**Patient/Guardian Signature** _____ **Date**_____

Jeff Plaster D.C. • 12002 County Road 11, Burnsville, MN 55337 • 952-808-2922 • eagletracespineandsport.com