MAYO THERAPY ASSOCIATES
3302 Fuhrman Ave E., Ste 110 Seattle, WA 98102 | Phone: 206-402-4012 | Fax: 206-588-0795

CONFIDENTIAL PATIENT INFORMATION

Please fill out completely, choosing relevant insurance information.

Demographics

Name: _____ Today's Date: _____

Preferred Pronouns: _____ Date of Birth: _____

How did you hear about us? _____ Social Security: _____

Email: _____ Phone: _____

Is it okay to Email you about scheduling, insurance, and/or payment topics specific to you and your treatment (please circle)? Yes No

Is it okay to phone you and leave messages.? Yes No

Address: _____

_____

City, State, Zip: _____

Marital Status: M S W D Spouse/Partner Name: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

☐ Medical Insurance Information (if billing Medical Insurance)

Insurance Company: _____ Member ID: _____

Group Number: _____ Policy Name: _____

Insured's Name: _____ Relation to Patient: _____

Have you confirmed massage coverage with your specific policy? Y N

Do you have an active Prescription with you today? Y N

Insurance Company Address: _____

_____

City, State, Zip:

☐ Labor & Industries/Worker's Compensation

Company (if not WA State L&I): _____ Claim Number: _____

Adjuster's Name: _____ Adjuster's Phone: _____

Supervisor/HR Contact Name: _____

Supervisor/HR Phone: _____

Insurance Company Address (if not WA State L & I): _____

_____

City, State, Zip: _____

☐ Personal Injury Protection (if in a Motor Vehicle Collision)

Insurance Company:		Adjuster's Phone:	
Adjuster's Name:		Adjuster's Fax:	
Claim Number:		Do you have PIP coverage?	Y N
		Is this the PIP Claim Number?	Y N
Insurance Company Address:			
City, State, Zip:			

☐ Legal Representation

Attorney's Name:		Phone:	
Legal Firm:		Email:	
Legal Assistant?		Phone:	
Address:			
City, State, Zip:			

Financial & Office Policies

As a courtesy, our office will bill your auto insurance company for personal injury claims, L&I (or other workers compensation company) for work related injuries or your health insurance companies. If your claim is a third party, we will file a lien against an attorney ONLY. We do NOT bill secondary insurances or file liens against insurance companies. You are responsible for all co-pays and for any remaining amount due after the insurance companies have rendered payment.

You are ultimately responsible for knowing what your benefits are and for keeping MTA up to date on any changes in your insurance coverage or benefit structure. Anything discussed between you and anyone at MTA about benefit coverage should not be construed as a guarantee of coverage. At MTA, we can offer our expectations based upon history of "like" insurance benefits but you must contact your insurance company directly and verify benefit coverage, limits, co-insurances, deductibles, etc. You are responsible for understanding those limits and passing that information on to our office.

If we are billing your insurance company, you must provide our office with a referral or prescription and all necessary information about your insurance company/plan/benefits, etc. You must fill out our paperwork completely. Any omissions or alterations that limit our ability to bill the insurance company or collect payment will result in you being responsible for the entire amount.

Personal injury cases must be verified with the insurance company. If you do not have PIP or MedPay coverage, you must pay at each visit. If the claim is or becomes a third-party claim (i.e. PIP coverage is exhausted,) we will transfer billing to your health insurance (if you have massage benefits). If you do not have massage benefits or those are or become exhausted, you must retain an attorney or pay for treatment at the time of service and seek reimbursement on your own. Any third-party balances accrue 1% monthly interest and billing fees (currently $5/month but subject to change.)

PIP balances will be held until settlement only for balances over $1000. Any balances below that amount must be paid in full. We will provide you with documentation to provide to your attorney or insurance company in order for you to seek reimbursement.

We require 24-HOUR NOTICE for any schedule changes. You are responsible for remembering when your appointments are. Patients who cancel or miss an appointment without 24 hours' notice will be subject to a no-show fee of $70/hour per missed appointment unless there is a medical emergency. If you arrive late, you will receive the time remaining for your appointment but be charged for the time you had reserved.

If you arrive more than 15 minutes late, your appointment may be forfeited, and you will be responsible for the no show fee. This fee is NOT covered by insurance companies and is your responsibility.

Fee schedules are available, and prices are subject to change. Time of service discounts are available to anyone, regardless of account type.

If health insurance benefits are exhausted, your account from that point forward will be converted to a self-pay account and so long as payment is received at the time of service, you will receive the "time of service discount." All dates unpaid by insurance companies because of exhausted benefits will be billed to you and are subject to the full rate billed the insurance company.

There is a $35.00 returned check fee.

Patient balances with past due amounts of 20 days or more will be subject to a rebilling fee. This fee is currently $5.00 but is subject to change.

Please INITIAL below. By initialing, I acknowledge that:

	I have investigated my health insurance benefits. I confirm that I have massage benefits (subject to deductibles and co-pays/coinsurance) and will alert MTA if my benefit plan or structure changes in anyway.
	I will assume responsibility for keeping my account current. Accounting charges of 1 %/month will accrue on past due accounts.
	All monthly statements for past due amounts are subject to a rebilling fee. Currently $5.00 but subject to change.
	Unpaid claims over 30 days become my responsibility. Unpaid fees over 120 days will be sent to collections of filed in small claims court unless payment arrangements have been agreed upon and paid, per agreement.
	In the event it becomes necessary to place for collection an unpaid balance due for services rendered or associated no show fees, I agree to pay COLLECTION FEES, and should legal action be filed, I agree to pay reasonable attorney fees, and other costs the court deems proper.
	I am aware that I am financially responsible for all no show or cancellations with less than 24 hours' notice.
	I understand that I am ultimately financially responsible for treatment received.
	I understand that rehabilitative massage is prescription based and medically focused. I need to follow the prescription AS WRITTEN or get an adjusted RX. I understand that not following the prescription can result in audits, denials (including retro denials) and that I am financially responsible for all treatment received. I understand that currently wellness massage is NOT reimbursed by insurance.

Financial Responsibility

I understand that insurance policies are an arrangement between my insurance company and myself. Furthermore, I understand that Mayo Therapy Associates, PLLC (MTA) will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the practitioner will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to myself are charged directly to me and that I am personally responsible for payment. I understand that if I do not adhere to my appointment schedule as agreed upon and do not make arrangements at least 24 hours in advance, I will be charged a no-show fee of $70.00. I am also aware that if I arrive late for my appointment I will receive the time remaining but be charged for the full appointment time I had reserved. A finance charge of 1% per month will be added to accounts over 30 days past due. To the extent permitted by law, if you are in default because you have failed to pay us, you will pay our collection costs, attorney fees, court costs and all other expenses of enforcing our rights under this agreement.

I authorize insurance benefits to be paid to the practitioner. I am financially responsible for the balance due. I authorize the practitioner or insurance company to release any information required to process this claim. Interest charges will be added to past due accounts.

_____ _____

Signature *Date*

_____

Print Name

Medical Information

Massage Treatment Information

What is the primary purpose for you seeking massage? _____

_____

_____

When did this start? _____ Have you missed work because of this? _____

_____ How much? _____

Had a similar condition previously? _____ How was it treated? _____

What has helped? _____

What makes it worse? _____

Is it (please circle): Getting Better Staying the Same Getting Worse

What has your pain been like in the past week? *none 1 2 3 4 5 impeding 6 7 8 9 10 bedridden*

How does this affect your ability to function? (check appropriate box; 0= not at all, 10= complete inability)

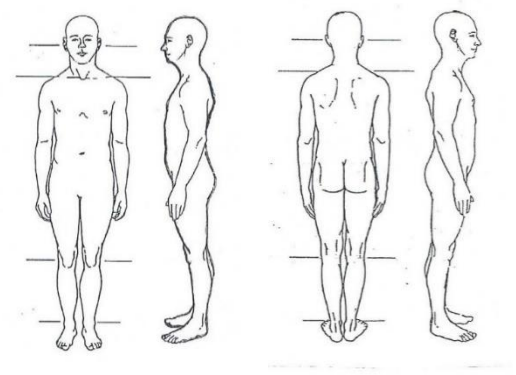
	0	1	2	3	4	5	6	7	8	9	10
Sitting											
Standing											
Walking											
Lying Down											
Climbing Stairs											
Rising out of Chair											
Bending Forward											
Lifting Objects											
Reaching Overhead											
Looking Over Shoulder											
Getting in/out of Car											

	0	1	2	3	4	5	6	7	8	9	10
Driving Car											
Household Chores											
Dress/Shower/Bathe											
Grocery Shopping											
Using a Computer											
Work Duties											
Yardwork											
Exercising											
Getting to Sleep											
Staying Asleep											
Concentrating											

Have you had professional massage before? _____ Any areas you would prefer NOT be touched? _____

What degree of pressure do you most commonly like? *Soft 1 2 3 4 5 Medium 6 7 8 9 10 Firm*

Please use the figures to indicate areas of pain (P), tension (T), and/or numbness/tingling (N)



General Health History

Do you currently have a primary care physician? If so, who?

Are you currently under the care of a chiropractor? If so, who?

Have you ever sustained a back or neck injury?

(please explain)

Have you ever had surgery? (if Yes, please list with dates)

Procedure	Year

Have you ever broken any bones?

(If yes, please list with dates)

Do you have any skin conditions? (boils, infectious rashes, active acne, lesions, etc) (If yes, please explain)

Do you have any autoimmune deficiencies? (i.e. HIV, Lupus, etc)

Do you experience numbness/ tingling? (If yes, please explain)

Do you experience Seizures?

Do you experience chronic Headaches?

How is your sleep?

How is your stress?

Please list all medications you are currently taking.

Medication	Condition

Please complete if pregnant

Due Date: First Pregnancy? **Y** **N**

Identified Risk Factors?

(please list)

Previous Pregnancy Complications?

OBGYN/Midwife Contact:

Do you currently or have you ever had any of the following? (Please check and explain when appropriate)

	Cancer
	Diabetes
	Fibromyalgia
	Heart Condition
	Circulatory Disorder
	Rheumatoid Arthritis
	Osteoarthritis
	Tendonitis
	Sprains/Strains
	Spinal Injuries/Surgeries
	Joint Disorder
	Artificial Joint
	Tennis Elbow
	TMJ
	Atherosclerosis
	Osteoporosis
	Deep Vein Thrombosis/Blood Clots
	Varicose Veins
	Phlebitis
	Circulatory Disorder
	Digestive Disorder
	Endometriosis
	Other Relevant Conditions

Please read carefully and sign

I understand that the massage treatment I receive at Mayo Therapy Associates, PLLC (MTA) or by any MTA contractors or employees is provided for the basic purpose of relieving muscular tension and/or following a prescription of an MD, DC, ANRP or PA and addressing issues based upon that prescription. I am aware that the massage therapist is NOT qualified to diagnose, examine, or treat any mental or physical illness or condition and that nothing discussed during my session should be construed as such. Information exchanged during any massage or therapeutic session is educational in nature and intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion. Additionally, anything discussed will remain strictly confidential. I know that massage therapy is not a substitute for a medical examination, diagnosis or treatment and I am seeking or have seen a primary care provider for any physical or mental ailment that I am aware of. Because massage therapy is contraindicated under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all of the above questions honestly. I agree to keep the therapist updated on any changes to my medical profile.

I understand that the therapist has the right to refuse service to anyone and will not provide massage to anyone under influence of alcohol or drugs. I also understand that it is my right as the client to terminate the session at any time if I am uncomfortable for any reason.

I agree to phone if I will be late to my appointment, understanding that I will receive only the amount of time in my scheduled time slot. I will give 24 hours' notice of cancellation or I will pay the no show fee of $70 per hour missed.

Signature *Date*

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Notice of Privacy Practices

MAYO THERAPY ASSOCIATES Privacy Practices are available for download at www.mayotherapy.com, and in print format on-site at the MTA Office.

I have read the MTA Notice of Privacy Practices and am aware that I have the right to a copy of this notice from MTA, upon request, even if I have agreed to accept this notice electronically.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Patient or Personal Representative