



Health History

NAME OF YOUR PRACTITIONER TODAY: _____

HOW DID YOU FIND YOUR PRACTITIONER? _____ (PLEASE BE SPECIFIC)

First Name _____ Last Name _____ Primary Phone _____

Birthday Month/Day/Year _____ Alternate Phone _____

Email _____ Occupation _____

Mailing Address _____

City _____ St _____ Zip _____ Emergency Contact: _____ Phone: _____

Are you Injured or in Pain or Discomfort? Where: _____

cuts, rashes, scrapes

numbness/tingling

varicose veins

osteo-arthritis

asthma

skin allergies

headaches or migraines

jaw pain

persistent cough

currently pregnant

heart condition

hi/low blood pressure

eating disorders

digestive disorders

colitis

sleeping disorders

depression

fatigue

diabetes: _____

cancer: _____

Herpes (1 or 2): _____

AIDS or HIV+: _____

Other Contagious Illness? _____

Any other Physical or Mental Health Conditions

Current Diagnosis

Current Medications:

Current Exercises/Activities, include frequency: _____

Surgeries (last 7 years): _____

Previous Accidents (list all and approx. year): _____

Have you ever received a professional massage? _____ What type? _____

What results do you expect from your massage sessions with Kneady Body & Feet? _____

Would you be interested in hearing about nutrition and supplements? _____

I believe the information I have stated above is accurate and understand omitting any information could lead to further physical/emotional complications after receiving any type of bodywork.

Client Signature: _____

Date: _____

All clients must sign the Clinic Policy as well. Thank you.



Medical Billing for Insurance Only

By signing below, you are acknowledging your financial liability for your requested services. Every effort will be made to collect billable charges from your insurance company. However, the therapist reserves the right to wait no more than 90 days following any billing procedure and should payment be delayed or refused you will be invoiced directly and responsible for paying all charges to the therapist within 30 days of receipt of the invoice. _____ **Signature**

First Name _____ **Last Name** _____

Date of Birth (month, day, year) _____

Current Condition (s): _____

Date of Injury or Symptom Onset: _____

Referring or Primary Care Physician Name: _____ **Phone #:** _____

Documented Diagnosis: _____ Date of Diagnosis: _____

Is this Injury from a Work-Related Accident? YES/NO Labor & Industry Claim Number _____

Primary Health Insurance: _____ **Member #:** _____ **Phone #:** _____

Secondary Insurance? _____ **Member #:** _____ **Phone #:** _____

Is this Injury from a Auto Accident? YES/NO Were you Driving? YES/NO Are you the driver at fault? YES/NO

Driver's License -- Issuing State: _____ Number: _____

Your Car Insurance Company _____ Claim Number _____

Representative Contact Name _____ Phone _____

Address for Sending Claims _____

3rd Party Claim? YES/NO If Yes, Insurance Company _____ Claim Number _____

Contact Name _____ Phone _____ Address _____

Attorney Name _____ Phone _____ Address _____

All Insurance and Coverage should be verified prior to your first treatment session. All charges incurred from treatment received prior to coverage verification is the responsibility of the patient. In order to bill Medicare you must have a secondary insurance as Medicare does not cover massage. We reserve the right to not re-bill secondary carriers.

Submit the following: My driver's license My referral form from my doctor My insurance card

Client Signature: _____ **Date:** _____

Witness or Therapist (print and sign): _____, _____ **Date:** _____



Clinic Policy

We are a clinic of massage associates. Each associate practitioner has his/her own state licensing, malpractice insurance and business licensing. They each operate their business in cooperation with Kneady Body & Feet Massage. You agree to not hold Kneady Body & Feet Massage, Tammy Foss, Sherwood Forest Office Park, its tenants or owners, or any other clinic associate personally liable for legal and financial issues or situations that arise with your independent practitioner. Clinic management is always open for suggestions and open to hearing issues that may arise between you and a clinic associate. Every effort will be made by clinic management to provide you with the highest quality service and the best practitioners in Puget Sound.

We are a HIPAA compliant office. Your Privacy is important to us. Your personal information will be protected within our clinic and not shared with anyone outside of Kneady Body & Feet Massage and its Clinic Associates. You may request a clinic association list from your practitioner. If your personal file needs to be reviewed by anyone outside of the clinic association, you will need to sign a release form.

We are educators. By agreeing to receive service at the clinic, you are opting in to receive education, announcements and offers through the mail from Kneady Body & Feet Massage Clinic & its Associates. Again, your personal information is never shared (nor sold) to third parties in compliance with HIPAA.

We are licensed therapists trained and licensed to help you heal. You are agreeing to work with a licensed massage practitioner as a client of WA state licensed massage services. You are agreeing to communicate with your practitioner immediately about any conditions or techniques during your work together that do not enhance your well-being. Failure to communicate all of your medical conditions may further damage your health. Any actions that may be construed as sexual advances or unsafe behavior will be reported to the police station.

We ask for your cooperation with our RULE of 24. In effort to provide all of our clients with outstanding service, 24 hours notice is required for all cancellation notices and rescheduling requests. Please respect our practitioners' time and our other clients' requests by providing us with 24 HOURS NOTICE.

When 24 hours notice is not provided, the following fees may be invoiced:

No-Shows = \$55 or the full rate of your appointment, which ever is greater.

Cancellation = \$24 for a called-in cancellation less than 24 hours (i.e. same day call-ins)

Rescheduling = \$15 for a called-in rescheduling less than 24 hours (i.e. same day call-ins)

Please note, that if you are more than 20 minutes late for a scheduled appointment, you will be required to reschedule and the rescheduling fee may apply. We reserve the right to treat each situation on a case-by-case basis. Payments are due upon receipt of the invoice.

Print Name _____

Client Signature _____

Date _____

Thank you for your business,
Clinic Manager