KNEADY Body & Feet

Health History

First Name _____ **Last Name** _____ **Primary Phone** _____

Birthday Month/Day/Year _____ **Email** _____

Occupation _____

Mailing Address _____ **City**_____ **St**____ **Zip**_____

Emergency Contact: _____ **Phone:** _____

□ Primary Focus During Visits: _____

CONSIDERATIONS:
□ numbness/tingling
□ osteo-arthritis
□ asthma or skin allergies
□ headaches
□ jaw pain
□ persistent cough
□ currently pregnant
□ heart condition
□ hi/low blood pressure
□ digestive disorders
□ diabetes
□ cancer
□ Herpes (1 or 2)
□ AIDS or HIV+
□ Other Contagious Illness?

LIMITATIONS of Physical Exercises/Activities: _____

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. I acknowledge that my practitioner is not licensed to diagnose any condition and it is my sole responsibility to ensure the safety of my health.

Client Signature: _____ **Date:** _____

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

Clinic Policy

We are a cooperation of multiple businesses. Each associated practitioner has his/her own state licensing, malpractice insurance and business licensing. They each operate their business in cooperation with/at Kneady Body & Feet Massage. You agree to not hold Kneady Body & Feet Massage, Tammy Foss, Lake Hills Professional Center, its tenants or owners, or any other clinic associate personally liable for legal, financial, interpersonal, or property issues that arise while being treated or visiting the clinic.

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. 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.

Patient Responsibilty. You agree 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 without discussion.*

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. However, each practitioner has his/her own guidelines. When in doubt, please ask.

No-Shows = no less than $55. Typically the full rate of your appointment.
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

KNEADY Body & Feet

Insurance Clients only

First Name _____ **Last Name** _____ **DOB:**_____

DIAGNOSED Condition(s): _____

Referring Physician Name: _____ Phone #: _____

Documented Diagnosis Codes (3-6 digits): _____

Date of Injury or Symptom Onset: _____

Primary Insurance: _____ Member #: _____ Phone #: _____

Secondary Insurance: _____Member #: _____ Phone #: _____

Work-Related Accident? YES/NO Labor & Industry Claim Number _____

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 Car Insurance Company _____ Claim Number _____

Contact Name _____ Phone _____

Attorney Name _____ Phone _____

All documentation and copays are due at the time of service. All Insurance and coverage should be verified prior to your first treatment session. All charges incurred from treatment are the responsibility of the patient. We reserve the right to not re-bill secondary carriers. 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.

Patient Signature _____ **Date** _____