Cyndislight

The sacred art of seeing someone through touch. MA 00016490

Personal Information:

full name date of birth

address

city state zip

home phone cell phone

email

occupation

referred by

emergency contact name emergency contact phone

physician's name physician's phone

Health History

Musculoskeletal

_____Bone or joint disease
_____Tendonitis/bursitis
_____Arthritis/Gout
_____Jaw pain (TMJ)
_____Lupus
_____Spinal problems
_____Migraines/Headaches
_____Osteoporosis

Circulatory

_____Heart condition
_____Phlebitis/Varicose veins
_____Blood clots
_____High/Low blood pressure
_____Lymphedema
_____Thrombosis/Embolism

Skin

_____Rashes
_____Cosmetic surgery
_____Athlete's foot
_____Cold sores/herpes

Respiratory

____Breathing difficulty/Asthma
____Emphysema
____Sinus problems
____Allergies, specify:

Nervous System

____Shingles
____Numbness/Tingling
____Pinched nerve
_____Chronic pain
_____Paralysis
_____Multiple Sclerosis
____Parkinson's Disease

Reproductive

_____Pregnant? Stage _____
_____Ovarian/menstrual problems

Psychological

_____Anxiety attacks
_____Depression

Current Health

Have you had any recent surgeries, accidents or injuries? Y N

If yes, please elaborate:

Do you have sensitive skin? Y N

If yes, please elaborate:

Have you ever had a professional massage? Y N

If yes, please explain what types (deep tissue, craniosacral, relaxation, etc)?

How long have you been receiving massage therapy?

How do you use your body on a daily basis (exercise, computer work, lots of standing, etc)?

List any medications you are currently taking:

Digestive

_____Irritable bowel syndrome
_____Bladder/Kidney ailment
_____Colitis
_____Crohn's disease
_____Ulcers

Other

_____Cancer/Tumors
_____Diabetes
_____Drug/Alcohol/Tobacco use
_____Contact lenses
_____Dentures
_____Hearing aids

Any other medical conditions not listed: _

Cyndi Hawkins, LMP ★ 206.349.2583 ★ cyndislight@earthlink.net

Client Agreement & Health Release Form

Insurance Information

client's full name _____ date _____

insurance I.D.# _____ date of injury _____

Is your condition the result of an auto accident? Y N

Work injury ( ) Health Condition ( ) Other ( )

Client's relationship to insured:

Self ( ) Spouse ( ) Child ( ) Partner ( ) Other ( )

insured's full name _____

insurance I.D. # _____

date of birth _____

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____

employer's name _____

primary insurance plan's name _____

group number _____ plan number _____

insurance company phone _____ fax _____

Insurance company billing address _____

city _____ state _____ zip _____

Secondary Insurance

name of the primary insured _____

date of birth _____

group number _____ plan number _____

phone _____ fax _____

plan's billing address _____

city _____ state _____ zip _____

Client Agreement

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature _____ Date _____

Assignment of Benefits

I am responsible for all charges for all services provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance after my copay.

I authorize and direct payment of medical benefits to my massage therapist **Cyndi Hawkins, LMP** for services billed.

Signature _____ Date _____

Signature of parent or legal guardian (if client is a minor) _____

Release of Medical Records

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claim.

Signature _____ Date _____

Signature of parent or legal guardian (if client is a minor) _____

Cancellation Policy

I understand that if I cancel my appointment in under 24 hours of the established appointment time that I will be charged the full amount of the appointment.

Signature _____ Date _____

Contract for Care

I will participate fully as a member of my healthcare team. I will make sound choices regarding my sessions' plan based upon the information provided by my massage therapist. I agree to participate in my own self-care programs and adhere to the plan we select. I agree to communicate with my practitioner any time I feel my well-being is being compromised. I expect my practitioner to provide safe and effective treatment to the best of her skills and knowledge.

Signature _____ Date _____