Advanced Neuromuscular Therapeutics
Medical Massage Therapy Clinic

CONFIDENTIAL CASE HISTORY

NAME: _____ DATE: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
AGE: ____ DATE OF BIRTH: _____ OCCUPATION: _____
PHONE: (H) _____ (W) _____ (C) _____
SS#:_____ REFERRED BY: _____ Email:_____
Have you had a professional massage before? _____ What type of pressure do you prefer? _____

CURRENT HEALTH

Present Symptoms (your major complaint): _____

_____

Date of Injury: _____ When did symptoms start? _____

In a few short words, describe the accident: _____

_____

_____

Were you wearing a seatbelt? _____Did the airbag release? _____ Standard or automatic? _____

What activities/in-activities aggravate the symptoms? _____

_____

Current Therapies? (PT, DC, etc…) Yes _____ No_____ Where? _____

Frequency? _____

Minor complaints (other areas of pain or concern RELATED to the injury): _____

_____

Does this affect your sleep pattern? Yes ____ No ____ Is it hard to go to sleep? _____
Do you have interrupted sleep? _____ Is it hard to get comfortable? _____
Describe your most comfortable sleeping position:_____

Do you feel your pillow is supportive? _____ Your mattress? _____

Date of X-rays _____ Date of MRI _____

WOMEN only: Are you pregnant? _____ If yes, what month? _____ Pregnancy # _____

Are you taking any of the following? Circle all that apply:

Anti-inflammatories Muscle Relaxers Pain med's Sleeping pills Aspirins
Anti-depressants Insulin Any Injections? _____
Prior to this visit, have you received treatment for this injury? (describe) _____

_____

CURRENT SELF CARE

Have you or are you using/doing the following?:

Ice Packs? _____ Heating pad? ____Epsom soaks or compresses? ____Stretching? _____ Ibuprophen ____

If yes,describe_____

_____

On a scale from 1-10 (10 being high) how high is your stress level? _____

(work, family, relationships, car, money....etc)

How long has your stress been like this?_____

Weekly exercise Activities: _____

Weekly habits:

Alcohol _____ average per week Coffee/Tea/Caffeine _____ average drinks per week

Tobacco _____ average per week Water intake _____ average ounces per day

EXPECTATIONS AND GOALS

Briefly describe: _____

_____

Have you ever:

	Yes	No	Briefly describe
Had any operations	____	____	_____
Broken bones?	____	____	_____
Been in a previous accident?	____	____	_____
Had Whiplash	____	____	_____

Other:

Do you wear orthotics? _____ Which is your dominant hand? _____

Which pocket do you carry your wallet in? _____ Do you sit on your wallet? _____

Which shoulder do you carry your purse on? _____

INSURANCE INFORMATION

Insurance Company: _____ Contact: _____

Billing Address: _____

Agent Name: _____ Phone #: _____

Attorney Firm and Name:_____ Phone #: _____

Claim Number: _____ Name of insured: _____

Do you have any difficult with the following? Put a P next to anything that is previous to the accident Circle all that apply.

Headaches	Light bothers eyes	Chest pains
Shooting head pains	Irritability	Shortness of breath
Grind teeth	Muscle spasms	Heart pain
TMJ pain	neck	High/Low Blood Pressure
Jaw popping	shoulders	Stomach trouble
Tightness in throat	mid back	Kidney trouble
Thyroid trouble	low back	Bladder trouble
Twitching of face	Tingling or numbness	Diabetes
Loss of memory	neck	Cancer
Fatigue	shoulders	Joint pains
Depression	arms	Any swelling
Head feels heavy or full	hands	Arthritis
Dizziness	buttocks	Disc herniation
Fainting	legs	Disc rupture
Loss of balance	feet	Slipped / Bulging disc
Ringing in ears	Weakness	Sciatica

THERAPIST NOTES / ADDITIONAL COMMENTS

_____

_____

_____

_____

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FINANCIAL RESPONSIBILITY AGREEMENT INSURANCE

Please read this agreement carefully. If you need clarification with any issue, we encourage you to ask.
As health care providers, it is important for us to clarify our standard procedures for billing insurance companies and patients at the beginning of treatment, so there is no confusion of misunderstanding. If you do not understand the following, a 5-10 minute meeting must be scheduled by your third treatment to explain these billing procedures and patient responsibilities in detail. This meeting is for our protection.

I agree to give 24-hrs notice of cancellation of my appointment. I understand that my therapist will schedule a minimum of one hour for each appointment. Unfilled hours will be billed to me at the rate $30.00 per hour.

I will keep my therapist informed of any changes in my health as they occur, including medicines, therapies, etc.

Self-care is assigned. Written instructions will be provided as to enhance your recovery. Please make every effort to participate in assigned stretching, soaks, and the use of heat or ice. Postural consideration may also be addressed.

I understand that my insurance is an agreement between the insurance company and myself.
I, _____, take **full responsibility** for all bills incurred for treatment.

We will assist in billing your insurance carrier; however, the responsibility of payment for services rests with the patient or guarantor. This means that, if your insurance company does not pay within 60 days of of date of service, or your deductible is not met, you are required to pay immediately-no exceptions.

Patient Information
All charges are determined by the therapeutic procedures performed and the amount of time spent by the therapist. Be aware that your treatment cost may vary because your insurance company determines the responsible and customary charges based on the therapeutic procedures perfomed and the amount of time spent. The prescription letter of referral written by your prescription letter of referral written by your prescription determines what body areas and therapeutic procedures we perform.

For group Insurance patients, our standard procedures and your responsibilities are the following:

1. Group insurance companies do not guarantee payment when benefit information is requested; therefore, it is your responsibility to pay for all bills that you incur if your insurance does not pay.
2. If your insurance does not cover your treatment, 100%, the co-pay is due at time of each treatment.
3. If your deductible is not met, immediate payment from you is expected.
4. All payment arrangements need to be discussed with the practice manager before treatment is received.

In the event that fees are not paid as requested, a collection agency and possible legal action may follow. If so, I will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I authorize payments to be made on my behalf to this provider for any services furnished.

I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

I authorize Advanced Neuromuscular Therapeutics/Carolyn Durham, Inc at any time I have an outstanding bill to be able to contact the insurance company for an exact dollar amount of benefits that I have left.

A copy of this agreement will be as valid as the original

I have read and I do understand the financial agreement thoroughly.

Signature _____ Date: _____

Section 8: Notice of Privacy Practices Acknowledgment and Authorization Form

Advanced Neuromuscular Therapeutics

Effective 02/28/2011

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Advanced Neuromuscular Therapeutics. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from Carolyn Durham.

Advanced Neuromuscular Therapeutics also used protected health information for the following reasons: (you may opt out of this authorization). Special initial authorization is required and attached.
Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial)

If you have any questions regarding this notice or our health information privacy policies, please contact:

Carolyn Durham is the Privacy Official
You can reach Carolyn Durham at: Advanced Neuromuscular Therapeutics, 419 West Bijou Street, Colorado Springs, CO 80905, 719-229-9235
Hours Available: A message may be left for Carolyn Durham any time the clinic is open and your call with be returned within 7 business days.

Your Email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature of Patient/ Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

Staff complete only if NO signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reasons why the acknowledgment was not obtained.

- Patient refused to sign this acknowledgment even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
- Other: _____

Staff Signature: _____ Date: _____