Advanced Neuromuscular Therapeutics
Medical Massage Clinic
HEALTH HISTORY

NAME _____ DATE OF BIRTH: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
PHONE (H): _____ (W) _____ (C) _____
EMERGENCY CONTACT: _____(Phone)_____
Your Email Address: _____
If using insurance: Insurance Co: _____ ID# _____
If you are the spouse or child, Insured Name:_____DOB _____
EMPLOYER/OCCUPATION: _____
REFERRED BY: _____
SEX: _____ Male _____ Female

Have you had a professional massage before? _____ What type of pressure do you prefer? _____
Current issue or complaint, or any Muscular / Structural / Joint / Bone / Circulatory problems. Please circle and explain: _____
_____

Current or previous medical problems (please circle and explain) Surgeries, Fractures, Skin Problems, Blood Clots, Phlebitis, Varicose Veins, Blood Pressure, Heart Condition, Cancer, Communicable or Infections Diseases or other significant medical problems: _____
_____

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?_____
Tell me about your daily and weekly self care (circle) stretching, ice, heat, vitamins, ibuprophen
Weekly exercise Activities: _____
Weekly habits:

| | |
|---|---|
| Alcohol _____ average per day | Caffeine _____ average drinks per day |
| Tobacco _____ average per day | Water Intake _____ average ounces per day |
| Sleep _____ average hrs/day | _____ Take Fish oil or Statin Drugs |

I certify that the above information is complete and correct. I will keep you informed of any changes as they occur. I understand that Advanced Neuromuscular Therapeutics will not be liable for any injuries or loss sustained to myself or property while on the premises.

I understand that the time of my appointment is reserved for me. If, for some reason, I am unable to keep a future scheduled appointment, I agree to give you 24-hrs notice. I understand that emergencies do occur, however, in the event of a last minute cancellation or no-show appointment, I will be charged $40 for my missed appointment of 60 minutes or $60 for my missed appointment of 90 minutes. As a prerequisite, we ask that you provide an active credit card to guarantee payment of your bill. Your card will be charged for any missed or late cancelled appointment.
I agree to the above terms and authorize you to bill my credit card for a missed appointment or late cancel. Initials: _____

FYI-Our office offers insurance billing, Carolyn Durham is a provider for many health care plans and all motor vehicle med-pay and workers comp plans. Check with your plan and see if massage is covered.

Signature _____ Date _____

**419 W Bijou St, Colorado Springs, CO 80905 Phone 719-229-9235 Fax 719-694-8170**

**For all clients we require a valid credit or debit card to be saved on your account**. For new clients we require to have a card on file 48 business hours in advance of your appointment. In the event of a late cancellation or a no show your card on file will be charged $40 for a 60-minute massage or $60 for a 90-minute massage. By signing below, you agree to the terms and authorize Advanced NMT to bill your card on file for any missed appointment or late cancel.

You can provide your card information below or you can give you card information over the phone. If we do not have your card information 48 business hours in advance of your appointment, your appointment will be cancelled.

***If you gave your card information over the phone or in office please fill in client name, card holder name and sign.**

Gave Card information over the phone or in office: Yes____ No____ (If no, please fill out all fields below)
Client Name: _____
Card Holder Name: _____
Card #: _____ Exp Date: _____ CVV: _____
Card Holder Signature: _____

Advanced Neuromuscular Therapeutics
Carolyn Durham, Inc.
Medical Massage Therapy

# Co-Pay Insurance Disclaimer

Please read this agreement carefully. If you need clarification, please speak with Carolyn Durham, owner.

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 or misunderstanding.

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

Advanced Neuromuscular Therapeutics and Carolyn Durham 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 service, or your deductible is not met, you are required to pay immediately, no exceptions.

Patient information, please fill out any information that you aware of:

My plan starts on _____ and ends on _____. I am entitled to _____ visits or $_____total during this period. I understand that my co-pay is $ _____ and is due and payable at time of treatment. If I exceed my alternative care allowance, I understand that I am responsible for full payment.

I have read and understand this financial agreement thoroughly.

Signature _____ Date _____

419 W Bijou St, Colorado Springs, CO 80905
Phone (719) 229-9235 Fax (719) 694-8170

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: _____

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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.

- o 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
- o Other: _____

Staff Signature: _____ Date: _____