Massage Intake Form

Personal Information

Name ______________________ Phone (day) ______________ (evening) ______________

Address ______________________ City/State/Zip ______________________ DOB __________

Occupation ______________________ Employer ______________________

Email ______________________ Primary Physician ______________________

Emergency Contact ______________________ Relationship ______________ Phone ______________

How did you hear about us? ____

Medical Information

Are you taking any medications? ☐ yes ☐ no

If yes, please list name and use: ______________________

____

Are you currently pregnant? ☐ yes ☐ no

If yes, how far along? ______________________

Any high risk factors? ______________________

Do you suffer from chronic pain? ☐ yes ☐ no

If yes, please explain ______________________

What makes it better? ______________________

____

What makes it worse? ______________________

____

Have you had any orthopedic injuries? ☐ yes ☐ no

If yes, please list: ______________________

Please indicate any of the following that apply to you.

- ☐ Cancer
- ☐ Headaches/Migraines
- ☐ Arthritis
- ☐ Diabetes
- ☐ Joint Replacement(s)
- ☐ High/Low Blood Pressure
- ☐ Neuropathy
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Heart Attack
- ☐ Kidney Dysfunction
- ☐ Blood Clots
- ☐ Numbness
- ☐ Sprains or Strains

Explain any conditions you have marked above:

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Massage Information

Have you had a professional massage before? ☐ yes ☐ no

What type of massage are you seeking?

☐ Relaxation ☐ Therapeutic/Deep Tissue

Other ______________________

What pressure do you prefer?

☐ Light ☐ Medium ☐ Deep

Do you have any allergies or sensitivities? ☐ yes ☐ no

Please explain ______________________

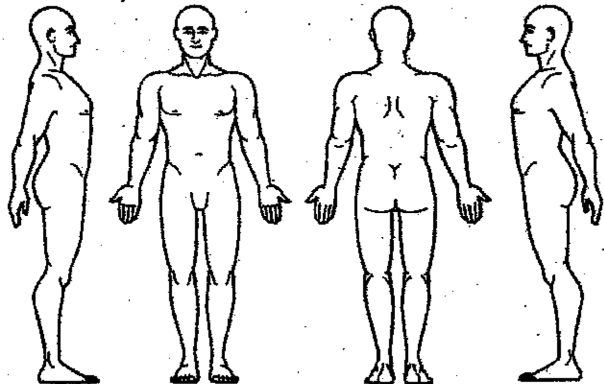
Are there any areas (feet, face, abdomen, etc.) you do not want massaged? ☐ yes ☐ no

Please explain ______________________

What are your goals for this treatment session?

____

Please circle any areas of discomfort



By signing below, you agree to the following.
I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time.

Client Signature ______________________ *Date* __________

Therapist Signature ______________________ *Date* __________

MASSAGE CONCEPTS

Bayport, NY 11705 • 749 Montauk Highway Phone (631) 313-8872 Fax (631) 363-4157
Garden City, NY 11514 • 1 Old Country Rd, Suite PL01 Phone (516) 227-5344 Fax (516) 227-5339
Massapequa, NY 11758 • 5418 Merrick Road Phone(516) 202-4150
Rockville Centre, NY 11570 • 77 Centre Ave, Suite 303 Phone (516) 321-9321 Fax (516) 608-2920

Dear Blue Cross/Blue Shield, United Health Care, MPN (empire plan), GHI, Aetna and Oxford Patients,

As a courtesy to you, we will submit your claims to your insurance company, even though we are non participating providers. We participate with the out of network benefits, and will verify ahead of time to confirm that you have out of network benefits. We will accept assignment. With some plans you may be required to make a co-payment. We only accept cash or check for the copay. BCBS, UHC, OXFORD and some other plans will not pay the provider directly. Payments may be sent directly to you.

IT IS YOUR RESPONSIBILTY AND WE ARE TRUSTING YOU TO BRING IN OR SEND EACH AND EVERY "EXPLANATION OF BENEFITS" (EOB) FORM WITH THE ORIGINAL CHECK, CO-SIGNED BY YOU ON THE BACK.

It is also your responsibility to submit any additional information requested from your insurance, otherwise you are responsible for payment

Since HIPAA and privacy act laws prevent us from retrieving information on the processing of your claims, we will depend on you for your full cooperation on this matter. If you do not comply with the protocol, we will have no alternative but to bill you directly and **IN FULL** for the services rendered.
Please assist us in the orderly handling of your account. Thank you
The above has been explained to me fully and I understand and agree to my responsibilities.

____
Full Name Printed

______________________________ *Date* ______________________
Signature

______________________________ *Date* ______________________
Witness

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Massage Scheduled Appointments and Cancellation/No-Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, if you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise when another patient falls to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not canceled "AT LEAST 24 HOURS IN ADVANCE", you may be charged a fee. The fee will be $50 for the full hour slot and $100 for the hour and a half slot. This will not be covered by insurance. If we are able to fill your appointment slot then you will not be charged.

If you are running late to your appointment, your appointment time will be decreased by the amount of time you are late, due to the fact that it will run into the next appointment and back up all appointments after you. If you do not show, you will be charged the FULL amount of your appointment.

PRINT NAME: ______________________________

Signature: ______________________________ Date: ______________