client agreement & health release form

insurance information

client's full name _____ date _____

ins. ID # _____ date of injury _____

Is your condition the result of an auto accident? ❒ Yes ❒ No

If so, in what state did the accident occur? _____

❒ A work injury? ❒ A health condition? ❒ Other _____

What type of insurance do you have that may cover you for this condition? *(check all that apply)*

❒ Auto ❒ Workers' compensation/state Industrial ❒ Liability ❒ Health

Was a police/accident report filed? ❒ Yes ❒ No

Client's relation to insured? ❒ Self ❒ Spouse ❒ Partner ❒ Child ❒ Other

insured's full name _____ insured's date of birth _____

insured's employer _____ ins. IS # _____

❒ Male ❒ Female ❒ Single ❒ Married ❒ Partnered ❒ Other

address _____

city _____ state _____ zip _____

home phone _____ cell phone _____

work phone _____

employer's name/school name _____

address _____ phone _____

primary insurance plan name _____

group number _____ plan number _____

phone _____

plan's billing address _____

city _____ state _____ zip _____

secondary insurance information

who is your attending physician? _____ name _____

address _____

city _____ state _____ zip _____

office phone _____ fax _____

Permission to consult with _____ regarding _____ Your initials _____

Has an attorney been retained? ❒ Yes ❒ No

name _____

address _____

city _____ state _____ zip _____

home phone _____ work phone _____

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 understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. 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. I understand that the american massage therapy association® has provided this form as a reference and is not held liable for any services provided.

signature _____ date _____

assignment of benefits

I am responsible for all charges for all service 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.

I authorize and direct payment of medical benefits to my massage therapist, _____ for services billed.

signature _____ date _____

signature of parent or legal guardian (if client if 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 claims.

signature _____ date _____

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

(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.)

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 his or her skills and knowledge.

I authorize and direct payment of medical benefits to my massage therapist, _____ for services billed.

signature _____ date _____

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

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by, _____, (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

_____

_____

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

I have received a copy of the therapist's policies, I understand them and agree to abide by them.

_____ _____

Client Signature Date