Federal Way Muscular Therapy, Inc.

33650 6th Avenue South Suite 100, Federal Way, Washington 98003
Phone (253) 942-3303 Fax (253) 815-8805

Patient Registration

Name: _____ Date of Birth: _____/_____/_____
Mailing Address: _____ City: _____ Zip: _____
Physical Address: _____ City: _____ Zip: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Please Circle One Gender: M F Status: S M D W Soc. Sec. #: _____
Employer: _____ Phone: ( ) _____
Address: _____ Occupation: _____
Emergency Contact: _____ Relationship: _____
Phone: ( ) _____
Referring Doctor or Provider _____ Phone: ( ) _____

Please answer the following questions:	**Yes**	**No**
Have you ever had a professional massage before?	____	____
Do you have any infectious or contagious disease?	____	____
Do you wear contact lenses?	____	____
Do you have any skin problems or allergies?	____	____
Do you have varicose veins or blood clots?	____	____
Do you have high blood pressure?	____	____
Do you have arthritis?	____	____
Do you have any heart problems?	____	____
Do you exercise regularly?	____	____

If Yes, how much and what kind? _____
Are you pregnant? If so, what stage? _____
Have you ever had surgery? If yes, please describe: _____
Are you on any medications? If yes, please explain: _____
Do you have any other medical condition that your practitioner should be aware of before you receive massage?
_____
Licensed massage practitioner comments: _____

Please read and initial each of the following paragraphs:

Purpose of Massage:

_____I understand that the purpose of massage is given for stress reduction, relief from muscular tension, spasm or pain; or, for increasing circulation or energy flow. I understand that the massage practitioner does not diagnose illness, disease, or any other physical or mental disorder, nor do they perform spinal manipulation. It has been made clear to me that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a Physician for any ailment that I might have.

_____I understand that sometimes there are changes to the schedule and that if the licensed massage practitioner I chose is sick or unable to work, I will be moved to another practitioner for that massage. All of our LMPs are highly skilled.

Financial Consideration:

_____Please note that in the event that you fail to make payment when due past 90 days, this account will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

_____I also understand that if I cannot keep my appointment and do not give at least **24 hours notice, I will pay a $35.00 fee** and this cannot be billed to my insurance

_____I understand that co-pays and co-insurance are due at time of service.

_____**Prescriptions or referrals are required to bill insurance. I understand that it is my responsibility to make sure I have one at the time of service. I also understand it is my responsibility to keep my prescription/referral up to date and current. If my insurance denies payment because of missing or expired prescriptions, I will be responsible for all charges.**

Signature: _____ Date: _____

Federal Way Muscular Therapy, Inc.

Specializing in soft tissue injuries

Health Insurance Information

PLEASE ONLY FILL OUT THE RELATIVE INFORMATION

Please provide referral or prescription at first appointment

Primary Insurance Carrier: _____ Phone Number: (_____) _____

Subscriber or Member Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN: _____ Employed By: _____

Secondary Insurance Carrier: _____ Phone Number: _____

Subscriber of Member Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN: _____ Employed By: _____

Auto Insurance Information

Personal Injury Protection (PIP)

Insurance: _____ Adjuster Name: _____

Phone: ( ) _____ Claim Number: _____

Policy Number: _____ State where accident occurred: _____

Date of Injury: _____/_____/_____ Estimated Damage: _____

****Third Party Claims are not accepted unless approved by management. Please consult with receptionist****

Work Injury Information

Please provide copy of claim form

Must have order for massage up to 6 visits allowed / Authorization needed after 6 visits

Is claim Federal: _____ State: _____ Private: _____ Date of Injury: _____/_____/_____

Claim Number: _____ Company: _____

Claim Manager Name: _____ Phone: ( ) _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Patient's Agreement

All of the above information is true to my knowledge. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in the collection of funds from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I understand that I am responsible for any and all charges my insurance does not pay. I also agree to pay any collection or attorney fees that should arise from nonpayment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient Signature:_____ Date: _____

Guardian Signature:_____ Date: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accounting Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

With specific written authorization, we are permitted to use and disclose your healthcare records for the purpose of treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- Payment means such as activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, treatment information is disclosed when billing a health plan for your health care services.
- Health Care Operations include the business aspects of running our clinic.

Unless you request, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments, send postcards, and/or leave messages at home and/or at work. Any other uses and disclosures will be made only as permitted by HIPAA regulations, or with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a writing request to our Privacy Officer at the practice office listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, relatives, close personal friends or any other person identified by you. We are, however, are not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The rights to access, inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information outside treatment, payment and healthcare operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April, 14, 2003 and we are required to abide by the terms of the privacy practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted.

You have the right to file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against your for filing a complaint.

For more information about our Privacy Practices please contact:
Teresa Fromm, Privacy Officer
Federal Way Muscular Therapy
33650 6th Avenue South Suite 100
Federal Way, WA 98003
(253) 942 3304

For more information or to file a complaint:
The U.S Department of Health & Human Services
200 Independence Avenue, S.W.
Washington D.C. 20201
877-696-6775 (toll free)

Acknowledgement of Receipt of Notice of Privacy Practices

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD

I have been given a copy of Federal Way Muscular Therapy "Notice of Privacy Practices".

_____ I do **NOT** have any questions

_____ I do have questions and would like the Privacy Office to contact me.
Phone Number to contact: _____
Best time to call: _____

Printed Name: _____

Patient Signature: _____ Date: _____

Notice given, but no signature _____

Reason: _____

_____