American Health & Wellness Center

Name_____ Phone (___) _____ DOB_____

Address_____City_____State_____ Zip_____

E-mail:_____

Referred by:_____ Phone (___)_____

In case of emergency:_____ Phone (___)_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible.

__Yes__ No Do you frequently suffer from stress?

__Yes __No Do you have diabetes?

__Yes __No Do you have a thyroid condition?

__Yes __No Do you have any allergies or sensitivities (i.e. nuts, shellfish, flowers, scents)?

__Yes __No Are you pregnant?

__Yes __No Are you wearing contact lenses or dentures?

__Yes __No Do you have high blood pressure and/or take medication to manage your blood pressure?

__Yes __No Do you suffer from back pain or disk herniation?

__Yes __No Do you have cardiac or circulatory problems?

__Yes __No Are you sensitive to touch or pressure in any area?

__Yes __No Do you have any contagious diseases?

__Yes __No Do you have osteoporosis?

__Yes __No Do you have frequent headaches?

__Yes __No Do you suffer from arthritis?

__Yes __No Any broken bones in the past 2 years?

__Yes __No Do you bruise easily?

__Yes __No Any Injuries in the past two years?

__Yes __No Do you have numbness or stabbing pains?

__Yes __No Do you suffer from epilepsy or seizures?

__Yes __No Do you have varicose veins?

__Yes __No Do you suffer from joint swelling?

__Yes __No Have you ever had surgery?

__Yes __No Other medical conditions or are you taking any medications?

Comments_____

_____

_____

Have you ever experienced a professional massage or bodywork session? __Yes __No How recently?_____

What are your goals for today's treatment?_____

What kind of pressure do you prefer? __ light __ medium __ firm

I understand that the massage/bodywork/spa treatment I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the treatment, pressure, and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination or the session, and I will be liable for payment of the scheduled appointment.

Client Signature_____ Date_____

Practitioner Signature_____ Date_____

Consent to Treatment of Minor: By my signature below I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian_____ Date_____

AMERICAN HEALTH AND WELLNESS CENTER
PAYMENT AGREEMENT

Your insurance policy requires the payment of co-pays and deductible amounts from you at the time of service. Your insurance company also requires that American Health and Wellness Center collect your copay or un-met deductible amount. Not adhering to these terms could be a violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

We verify benefits as a courtesy to you. However, American Health and Wellness Center does not accept any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

Some insurance policies do not cover all of our therapies. Your treatment plan is between you and Dr. Petrie. If he believes you would need these therapies to improve health, you would be responsible this portion of the payment .

Our front office staff can accept payment from you in the form of cash, check or credit card. As a courtesy, we will bill you're your insurance company for their portion of the bill. Feel free to ask questions of us as you receive "Explanation of Benefits" (EOB) from your insurance provider.

Please verify that you understand your financial responsibility by signing and dating this form and let us know if we can assist you in any other way.

Patient Signature: _____

Print Name: _____ Date: _____

Staff Initials: _____