

1223 Higuera Street, Ste. #101 • San Luis Obispo, CA 93401 • (805) 781-9155 • www.powersourcechiropractic.com

Name _____ Phone: _____ DOB _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Email _____ Referred by _____

Have you ever had a massage? _____ When was your last massage? _____

Primary Complaint: _____ How long have you noticed this? _____

◆ I confirm that I am not presenting any of the following symptoms related to COVID-19: _____(initial)

◆ Fever ◆ Dry Cough ◆ Shortness of Breath

◆ Runny Nose ◆ Sore Throat ◆ Loss of Sense of Taste or Smell

Please check if you have or had had any of the following:

- | | | |
|-----------------------------------------------------------|--------------------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Severe or Frequent Headaches | <input type="checkbox"/> Shingles | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Jaw Pain | |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Low Back Pain | |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Asthma/difficulty breathing | |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Herniated Disk | |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Skin Disorders (i.e. Athletes Foot) | |
| <input type="checkbox"/> Back Pain ___Low ___Mid ___Upper | | |

Are you pregnant or is there any chance of pregnancy? Yes No I don't know

Are you under a physician's care? Yes No If Yes, who is your Dr.? _____

Do you have any difficulty lying on front/side/back? _____

Please list your medications: _____

Please list any Medication Allergies: _____

Do you have any allergies to lotions/oils? _____

Pressure: Which do you prefer? Light Medium Medium-Deep Deep I Don't know

Are there any areas that are particularly sensitive or ticklish? If so, please indicate: _____

What results would you like from this massage? _____

Depending on necessity of use, would you like me to use essential oils and/or deep heating lotion to aid in the therapeutic process? Yes No

Please check the areas that you give consent to receive massage:

ALL AREAS INDICATED BELOW:

Face Hips Arms Feet Glutes Legs Shoulders Hands Neck Back

I understand that this is my choice to receive Massage Therapy. I understand that Massage Therapy is non-sexual Therapeutic Massage given with the aim to reduce stress and for the relief of minor tension, pain or spasm. To the best of my knowledge, I have provided accurate information concerning my personal health. Massage Therapists do not diagnose or treat medical conditions. An health concerns should be brought to the attention of your health care provider. I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

Signature _____

Date _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I have received Powersource Chiropractic's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care options.
- A description of each of the other purposes for which this practice is permitted or required to use to disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to such a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Due to its participation in the Electronic Health Records Stimulus Program and the requirements of the HI-TECH act, Powersource Chiropractic is required to provide to me a Clinical Summary report after every visit. However, due to the nature and frequency of chiropractic care, these summaries are often blank. My signature below indicates my wish to *decline* receipt of my Clinical Summary on each visit. Should I require a copy of my treatment notes for any given appointment, I understand that this clinic is required to provide me this information within 4 business days of my request.

Patient Signature

Date

Relationship to patient (if not self)

Powersource Chiropractic Minimum Bill/Charge Fees

The fees we set are done so to comply with the insurance regulations. Please understand that Powersource Chiropractic massage fees range from \$51-\$408 per visit based on the amount of time and the specific procedures performed. The fees we have set are based on what is "Usual and Customary" for our county and state and what the insurance companies have deemed fair and reasonable.

- **Co-payments:** We will do our best to determine your *estimated* co-payment based on the information that your insurance company provides when we verify your coverage. This depends on the insurance company and plan type. **Please understand that many times insurance companies have no way of knowing what procedures they will cover until the claim is received which can take anywhere from 30-45 days after the services were rendered.** Once the Explanation of Benefit (EOB) is received from the insurance company we will have an exact co-payment figure available for you.

Estimated Co-payment \$_____ 1HR \$_____ 1/2 HR

- **You are ultimately responsible for services rendered to you.** It is important to understand that if your insurance company does not cover certain services rendered that you are ultimately responsible for your bill. Please be aware that if your insurance denies payment, you will not be responsible for the full billed amount: you will be responsible for our **Minimum Bill Fee.**

The usual and customary rate based on our state and county is:

1 unit of Muscle Therapy=15min=\$51.

Length	Units	Billed Amount
30min	2 units	\$102
60min	4 units	\$204
90min	6 units	\$306
120min	8 units	\$408

I have read and understand the above guidelines and wish to receive treatment at this time.

Name

Date

Signature

Witness

Muscle Therapy Policies

The following are our policies regarding our muscle therapy or trigger point therapy services:

Appointment times are specific: Your time starts at the appointed time and thus ends in the allotted time frame. If you arrive late, you will have a shorter massage for the same fee. It is important that you understand that the time for your muscle therapy session includes the following:

1. Time to undress and dress: approximately 2 to 3 minutes total.
2. Consultation: Initial session 5 minutes, subsequent sessions 2 to 3 minutes each.
3. Explanation of home stretching or therapy: 2 to 3 minutes as needed.

24 hour cancellation policy: We require a 24 hour notice for cancellation or reschedules. You will need to notify us 24 hours before your appointment to cancel or reschedule or you will be charged for the appointment. We will not bill your insurance for this fee.

Treatment attire and personal conduct: Each treatment varies, but please arrive clean, and in comfortable clothing for your muscle therapy session. Because muscle therapy can release toxins into the body, no alcohol or illicit drug consumption before your session will be tolerated, and your therapist reserves the right to re-schedule your appointment for another date. This is for your safety, as well as the therapist's.

Payment is due at the time of service: Powersource Chiropractic is only legally allowed to offer you a Pay at the Time of Service Discount if payment is received at the time of service. If payment is delayed to a later time you will be responsible for our Minimum Bill Fee. If you have insurance that will cover Muscle Therapy services then your co-payment is due at the time of service. (Please reference Powersource Chiropractic Minimum Bill/Charge Fees)

Please sign your name below indicating that you have read, understand and abide by the above policies.

Print Name

Date

Signature

Witness