CORNERSTONE
CHIROPRACTIC

Name _____ Nickname _____ Date _____

Home Address_____ Apt. #_____

City_____ State _____ Zip _____

Home Phone_____ Cell Phone _____ Email _____

Date of Birth _____ Age _____ ·Male ·Female Marital Status: ·Single ·Married ·Divorced ·Widowed

Student: ·Full time ·Part time ·Non-student Social Security # _____

Employer_____Occupation_____·Full time ·Part time

Name of Spouse _____Spouse's Birth Date _____

Name and Age of Children_____

Person to contact in case of Emergency: _____ Phone_____

Referred by: ❑Drive by/walk in ❑Insurance list ❑Website ❑Online (Circle one) Yelp, Google, Facebook, Other_____

❑Patient referral _____ ❑Previous Patient ❑Another Provider_____

Is there any area where you would like extra time spent? Is there any area where you have muscle pain, stiffness or tension (neck, low back, shoulder, other)?

What is your previous experience with professional massage?

Daily Habits:

Do you exercise? ·Yes ·No Type of Exercise _____ Frequency _____

Do you smoke? ·Yes ·No How much per day? _____

Do you drink alcohol? ·Yes ·No Frequency and Amount _____

Do you drink coffee/tea/caffeinated beverages? ·Yes ·No Quantity _____

Height_____ Weight_____

Hobbies: _____

Medical History - Please indicate below any significant medical problems, as such conditions can influence the type and/or depth of work done in any given area. Thank you.

_____ Allergies
_____ Skin condition (acne, rash, allergies, skin cancer, other):
_____ Lymphatic condition (swollen glands, lymphoma, lymphedema, other):
_____ Recent injury or accident (whiplash, sprain, deep bruise, other):
_____ Circulatory condition (heart disease, varicose veins, phlebitis, arrhythmia, arteriosclerosis, other):
_____ Neurological condition (sciatica, numbness/tingling of any area of skin, stroke, epilepsy, other):
_____ Joint problems, pain, or stiffness (osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, sacroiliac problems, other):
_____ Bone conditions (osteoporosis, previous fracture, cancer, other):
_____ Headaches (migraines, PMS, tension, cluster, other):
_____ Emotional difficulties (depression, anxiety, psychotic episodes, other):
_____ Stress
_____ Previous surgery, please state type and date:
_____ Other medical considerations:
_____ List any medications you are currently taking:
_____ Can you lie comfortably on your stomach? _____ Can you lie comfortably on your back? _____
_____ Are you pregnant?
_____ Do you have any body piercings that would be affected by heat (such as belly piercings)?

Name of Health Care Provider: _____ Phone: _____

Signature_____Date_____

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1. All payments are due at the time of service. 2. All massage appointments require 24 hours' notice for cancellation or any schedule changes. There is a $65 fee for no-shows or changes less than 24 hours. Such fees are not covered by insurance and are your responsibility. Because we specifically set time aside for you, we ask that you respect the therapist's time and show up for all appointments. This policy will be strictly adhered to in our office.

3. Please be on time for your appointment. If you arrive late, you will be seen by the therapist for the remainder of your appointment; however, you will be responsible for payment of the full time slot scheduled. Please arrive early if you need to use the restroom or attend to other matters.

4. Hands on time for massage is approximately 50-55 minutes for a one-hour massage. This allows time for the therapist to perform charting and change the sheets for your appointment.

5. If you have a referral for massage therapy from a physician, you must follow the specific care plan and frequency set forth in the referral. If not, your visits may not be covered by your insurance and you will be responsible for all unpaid services.

6. It is strongly recommended that you not bring your children with you to your massage therapy appointment. If a child must accompany you to your appointment, the child must remain with you during your massage.

7. Payments and Co-pays are expected at the time services are rendered. Pre-payment plans are available to save time and money. Ask the front desk for details.

8. The patient is financially responsible for all services rendered to them in our clinic, regardless of insurance payment. A current fee schedule is available to all patients upon request.

9. It is the patient's responsibility to verify insurance benefits and notify the front desk of any changes in insurance benefits. When we speak to insurance companies, we are not always given correct or up-to-date information. We are not responsible for incorrect information given by your insurance company. The best way to verify information is by consulting your written insurance policy.
I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

CONSENT TO TREAT: By signing this form, I am giving consent to have massage therapy.
ASSIGNMENT AND RELEASE: I authorize release of my health care information to other healthcare practitioners. I authorize release of my health care information to insurance companies. I authorize my insurance benefits to be paid directly to: Cornerstone Chiropractic, Inc. PS.

HIPAA (HEALTH INSURANCE PORTABILITY AND PRIVACY ACT) Cornerstone Chiropractic may need to use your name, address, phone number and clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you. If you are not available, a message may be left on your answering machine or with a family member, unless you specifically state otherwise here._____ We perform online insurance billing services through an insurance clearinghouse and paper claims for auto accident and L&I. All your healthcare information is protected in this process by HIPAA. You have the right to refuse us this authorization. You may add restrictions to or revoke this authorization as described in the Notice of Health and Information Practices accompanying this document, I authorize Cornerstone Chiropractic Inc. PS to use or disclose my health information in the manner described above. I also understand that I may request a copy of this form.

Signature_____Date_____

Print Name_____