

**Consent For Care**

I, \_\_\_\_\_, hereby grant permission to all providers at 5191 S. Yosemite Street to perform such examinations and therapeutic treatments. Clinicians who may treat me include, but are not limited to; acupuncturists massage therapists, Pilate’s instructors, herbologists, and chiropractors.

I understand that my record will be kept confidential and will not be released to others unless they are involved in my care plan. I understand that I may look at my records at anytime and I can request a copy of it. I am not forced by anyone to accept medical treatment.

**Authorization To Release Information**

I AUTHORIZE all providers to release any information required to process this claim to any insurance company or attorney in this case. I also authorize any insurance company or medical provider to release my medical records to ALL providers here. This information is to be used for the purpose of preceding my claim for benefits due. I hereby agree that a photocopy of this document is valid and effective as the original copy.

**Payment Agreement**

I hereby authorize my insurance benefits to be paid directly to ALL providers. I assume full responsibility for and agree to pay all costs, charges and expenses of every kind and service furnished by ALL providers. I must pay charges and services not covered by any insurance or third-party and/or not paid to ALL providers for any reason within a time period ALL providers deem reasonable, The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third party responsible for payment of the charges.

**Cancellation Notice**

KINDLY GIVE 24 HOURS NOTICE OF CANCELLATION. LATE CANCELLATIONS ARE SUBJECT TO A 50% CANCELLATION FEE. Call-backs are a courtesy and you are ultimately responsible for your appointment.

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Your Printed Name

Signature

Date

## **Consent for Purpose of Treatment and Healthcare Operations**

*In this document, "I" and "my" refer to the patient/client*

I consent to the use or disclosure of my protected health information by Integrative Health for the purpose of analyzing, diagnosing and providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by Integrative Health may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice, Integrative Health is not required to agree to the restrictions that I may request. However, if Integrative Health agrees to a restriction that I request, the restriction is binding on Integrative Health. I have the right to revoke this consent, in writing at any time, except to the extent that Integrative Health has taken action in reliance on the consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, health plan, my employer or a health care clearing house. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may obtain a copy of the Notice of Privacy Practices of Integrative Health and understand that I have the right to read that Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Integrative Health, as well as my rights and duties of Integrative Health with respect to my protected health information. The Notice of Privacy Practices for Integrative Health is located in our waiting room.

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Printed Name of Patient

Signature of Patient or Personal Representative

Date

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Description of Personal Representatives Authority



# INTEGRATIVE HEALTH, INC. WELLNESS CENTER

EXPERTS PROVIDING NATURAL HEALTHCARE

5191 S. Yosemite, Suite B, Greenwood Village, CO 80111

Phone: 303-577-9977 Fax: 303-694-4341

www.integrativehealthinc.com

## Massage Client Information

Please fill out the following information prior to your appointment.

### Client Information

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Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
*(if using medical insurance with payment)*

Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street City Zip*

Emergency Contact Name: \_\_\_\_\_ Contact's Phone: (\_\_\_\_) \_\_\_\_\_

Your Date for Birth: \_\_\_\_\_  
*Month Day Year*

Gender: Male | Female  
*(please circle)*

Are you currently under medical care? Yes | No  
*(please circle)*

Place of Occupation: \_\_\_\_\_

### Insurance Information

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**Medical Insurance:** If you are using medical insurance today, please clip your card to the clipboard so we may make a photocopy for our records.

**Auto Insurance:** if you plan on billing under auto insurance due to a motor vehicle accident or Workman's Comp, please bring this to the receptionist's attention.

### Reason for Visit

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How did you hear about us? \_\_\_\_\_

	Yes	No	
Are you here because of an injury?	<input type="checkbox"/>	<input type="checkbox"/>	If so, Please explain: _____ _____ _____
Is your injury work-related?	<input type="checkbox"/>	<input type="checkbox"/>	
Is your injury auto-related?	<input type="checkbox"/>	<input type="checkbox"/>	

What is the purpose of your massage today? \_\_\_\_\_

What are your expectations? \_\_\_\_\_

Are you Pregnant? Yes | No If yes, how many months? \_\_\_\_\_

List any over the counter medications you are currently taking. Please include any herbal supplements, vitamins, etc.

\_\_\_\_\_

Do you have any questions, concerns or special needs? \_\_\_\_\_

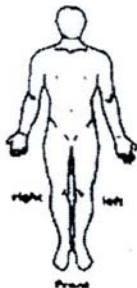
\_\_\_\_\_

## Your Medical History

*Please check any conditions you have or had. Please also check if any of the following are a significant part of your medical past.*

<u>Have</u> <u>Now</u>	<u>Had</u>		<u>Have</u> <u>Now</u>	<u>Had</u>		<u>Have</u> <u>Now</u>	<u>Had</u>	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Birth Trauma (your own)	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Surgery (list) _____	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox			_____	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			_____	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			_____	<input type="checkbox"/>	<input type="checkbox"/>	Tachycardia
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Major Trauma (car, fall, etc, list)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Musculoskeletal</b>
<input type="checkbox"/>	<input type="checkbox"/>	Gout			_____	<input type="checkbox"/>	<input type="checkbox"/>	Neck/Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease			_____	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis			_____	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Rib Pain
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever	<input type="checkbox"/>	<input type="checkbox"/>	Limited Range of Motion
<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Limited Use
<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	Lower Back Pain
						<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

Please indicate areas of pain:



## Survey

Your feedback directly impacts the quality of service we provide. Please take a moment after your treatment to fill out this survey.

Name (optional): \_\_\_\_\_ Phone: \_\_\_\_\_

1. Overall, how was your visit? (please circle)    Extremely Enjoyable    Average    Unacceptable

2. What type of treatment did you receive on this visit? (massage, acupuncture, etc.)  
 \_\_\_\_\_

3. Did you enjoy the treatment? (please circle)    Extremely Enjoyable    Average    Unacceptable

4. Was this your first visit? (please circle) Yes | No

If no, roughly how many times have you been here? 2-5 | 10-20 | other: \_\_\_\_\_

If no, what treatments do you usually get? \_\_\_\_\_

5. How did you hear about us or the treatment you came in for today?

- |  |   |
|--|---|
| <input type="checkbox"/> Website/Search Engine               | <input type="checkbox"/> Referral by Friend: _____      |
| <input type="checkbox"/> Newspaper                           | <input type="checkbox"/> Referral by Medical Dr.: _____ |
| <input type="checkbox"/> Mailing                             | <input type="checkbox"/> Referral by Other: _____       |
| <input type="checkbox"/> Signage in the Reception Area       | <input type="checkbox"/> Was Given a Gift Certificate   |
| <input type="checkbox"/> Service performed at your workplace | Service: _____ Workplace: _____                         |
| <input type="checkbox"/> Other: _____                        |   |

6. We offer seminars on weekends and some week nights featuring mental health, nutrition, exercise, etc. Are there any seminars (listed above or not) that you would be interested in attending? Yes | No

If yes, please note: \_\_\_\_\_

7. We occasionally send out emails that include discounts, seminar information, and upcoming events. In the future, we plan to send email reminders for appointments. If you are interested in receiving such emails, please provide your email address below. By providing your email address, you are giving us permission to send you email as described above. *Your email is safe with us. We will NOT give your email address to any third parties.*

Email: \_\_\_\_\_