



Policies and Procedures

Welcome to Edmonds Massage Center! The following is an explanation of our office policies and procedures. We believe that a clear understanding will allow us both to concentrate on the most important issue: regaining and maintaining your health. We are happy to answer any questions that you may have and grateful to be at your service.

The procedure time for your treatment is 45-60 minutes. When you schedule, one full hour set aside specifically to meet your needs. We do not double book appointments and are unable to place another client in your space without sufficient prior notice. Therefore when you are scheduled, it is imperative that you make your appointment and that you arrive on time.

Our time is valuable too. Cancellation notice is required **24** hour prior to your treatment time. **24** hours allows us to make your time slot available to another client in need of treatment. If notice is not given, there will be a \$40.00 charge to your account. We are unable to bill your insurance for cancellation fees. It is solely your responsibility. **THE FEE MUST BE PAID PRIOR TO YOUR NEXT APPOINTMENT.**

Our billed massage therapy fees for Injury Treatment Massage are \$27.50-\$35.00 per unit (4 units=1 hour). If the massage session is paid in full at the time of service, "time of service discount" will apply. Under no other circumstances will this fee be adjusted. I understand and agree that the policies and procedures are an arrangement between carrier and client. Insurance will be certified and billed as a courtesy to you; however, the client understands that he or she is responsible for treatment not covered by the insurance. In the event that your insurance denies payment, you the client become responsible for payment in full. A 1% interest per month will be charged on balances over 60 days.

It is my choice to receive massage therapy. I realize and understand that massage therapists do not diagnose or prescribe. I agree to communicate with my practitioner regarding any changes in my insurance plan or circumstances. I further agree to communicate with my practitioner any time I feel my well-being is being compromised.

MY SIGNATURE INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE.

CLIENT SIGNATURE: _____

PRINTED NAME: _____ DATE: _____

EDMONDS MASSAGE CENTER
CONFIDENTIAL HEALTH INTAKE FORM

NAME: _____ BIRTHDATE ____ / ____ / ____

Please answer the following questions by circling yes or no and provide any necessary clarifications.

- YES NO Have you ever had a professional massage?
YES NO Do you exercise regularly or participate in any sports? What kind and how often?

YES NO Are you currently under the care of any other health care provider for a specific condition?
YES NO Do you take any vitamins, minerals, or medication (including aspirin or ibuprofen) Please list medication, dosage, and condition _____

YES NO Have you ever had surgery? Please list date(s) and procedure(s) _____

YES NO Do you have or have you ever had cancer? What type and when? _____

YES NO Do you have or have you ever had heart problems? Please explain: _____

YES NO Do you have high or low blood pressure? Please circle one.
YES NO Do you have varicose veins, blood clots or any other circulatory conditions not mentioned? Please explain: _____

YES NO Do you have diabetes? How is it controlled? _____
YES NO Do you have arthritis? Osteoarthritis or Rheumatoid? (please circle one) Where is it located? _____

YES NO Do you have bone or joint problems? Please describe: _____
YES NO Do you experience prolonged episodes of depression or other emotions?
YES NO Do you have any infections or contagious diseases? Please explain: _____

YES NO Are you experiencing any sleep disorders or changes in normal sleeping patterns? Please explain: _____

YES NO Are you pregnant? What stage? _____
YES NO Do you wear contacts, dentures, or hearing aids? _____
YES NO Do you have any other medical conditions your therapist should be aware of before you receive massage? _____

YES NO Do you have any needs that require special attention? Please explain: _____

Please read carefully, sign, and date.

I understand that massage therapists do not diagnosis illness, disease or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that is recommended that I see a physician for any ailment I may have. I have stated all my known medical conditions and I am responsible to inform my massage therapist of any changes in my physical or mental health. I understand that my massage therapist is an independent contractor at Edmonds Massage Center, LLC. I indemnify and hold harmless Edmonds Massage Center, LLC from any loss or liability arising from services provided by my massage therapist.

SIGNATURE _____

DATE ____ / ____ / ____

EDMONDS MASSAGE CENTER PATIENT REGISTRATION FORM

LAST NAME: _____ FIRST NAME: _____ M.I. _____

SOCIAL SECURITY #: _____ - _____ - _____ BIRTHDATE: ____/____/____

ADDRESS _____

CITY: _____ STATE: _____ ZIP CODE: _____

CELL# _____ - _____ - _____ HOME# _____ - _____ - _____ WORK# _____ - _____ - _____

DRIVERS LICENSE # _____

EMAIL: _____

PLEASE CIRCLE ONE: SINGLE - MARRIED - DIVORCED - WIDOWED – OTHER

EMPLOYED? FULL TIME / PART TIME STUDENT? PART TIME / FULL TIME

SCHOOL / EMPLOYER: _____

EMERGENCY CONTACT: _____ # _____ - _____ - _____

HOW WERE YOU REFERRED TO EMC? _____

WOULD YOU LIKE US TO VERIFY YOUR MASSAGE THERPAY BENEFITS?

PRIMARY INSURANCE: _____

SUBSCRIBER NAME: _____ BIRTHDATE ____/____/____

SS# _____ - _____ - _____ SUBSCRIBER EMPLOYER: _____

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX) _____

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

*SECONDARY INSURANCE: _____

SUBSCRIBER NAME: _____ BIRTHDATE ____/____/____

SS# _____ - _____ - _____ SUBSCRIBER EMPLOYER: _____

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX) _____

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

**CONTRACTUAL GUARANTEE OF PAYMENT
FOR HEALTH CARE SERVICES**

I hereby authorize and direct you, my attorney, to pay directly to **EDMONDS MASSAGE CENTER** such sums as may be due and owing in regards to date of loss _____ for health care services for injuries arising from a motor vehicle accident. I hereby authorize my attorney and involved insurance companies to withhold sums from any settlement, judgment, or verdict as may be necessary to adequately protect said office. I hereby further consent to a lien being filed on my case by said office against any and all proceeds of my settlement, judgment, or verdict which may be paid to you, my attorney, or me as the result of the injuries for which I have been treated.

I agree to never rescind this document and that any attempt to rescind this document will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney shall honor this Contractual Guarantee of Payment for Health Care Services as inherent in the settlement and enforceable upon the case as if it were executed by him/her.

I fully understand that I am directly and fully responsible to said office for all health care bills submitted for services rendered to me. Further, this agreement is made solely for said office's additional protection and in consideration of forbearance on payment. I understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover damages. **Also, I understand that my responsibility to pay (the clinic's) bill is independent and separate from (the clinic's) right to file a lien to protect its financial interest under RCW 60.44.**

I specifically request my attorney to acknowledge this letter by signing below and returning it to the clinic's office. I have been advised that if my attorney does not wish to cooperate in protecting the clinic's interest, the clinic will not await payment, but will require me to make payments on a current basis. With balances over 90 days I will pay interest at 1% month (12% annum).

PATIENT SIGNATURE

DATE

PATIENT DRIVERS LICENSE NUMBER

PATIENT'S SOCIAL SECURITY NUMBER

The undersigned, being attorney of record for the above patient, does hereby agree to observe all the terms of the above, and agrees to withhold such sums from any settlement, judgment, or verdict as may be necessary to adequately protect said office named above.

SIGNATURE OF ATTORNEY

DATE

Please date, sign, and return one original to:
EDMONDS MASSAGE CENTER.
6603 220th Street South West Suite 1-C
Mountlake Terrace, Washington 98043
Thank you,

Kelly Kozelisky
Owner