



6603 220th ST SW Suite 1-C
Mountlake Terrace, W A 98043
(P)425.776.1056 (f)425.776.4357

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 are scheduled, one full hours is 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 hours 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 \$25.00 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 YUR NEXT APPOINTMENT.**

Our billed massage therapy fees for Injury Treatment Massage are \$20.65 - \$27.50 per unit (4 unite = 1 hour). If the massage session is paid in full at the time of service, a 'time of service discount' will apply. Under no other circumstances will this fee be adjusted. Understand and agree that the policies and procedures are an arrangement between carrier and client, Insurance will be verified 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 you insurance denies payment, you the client becomes responsible for payment in full. A 1% interest per month will be charged on balances over 60 days.

It is my choice to receive message therapy. I realize and understand that massage therapists do not diagnose or prescribe. I agree to communicate with my practitioner regarding any changes to 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: _____ Date: _____

Printed Name: _____

Edmonds Massage Center

Confidential Health Information Form

NAME _____ BIRTHDATE _____
ADDRESS _____
PHONE _____ WORK/CELL _____ EMAIL _____
OCCUPATION/EMPLOYER _____
EMERGENCY CONTACT & PHONE _____

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? Please explain _____
YES NO Do you take any vitamins, minerals or medication (including aspirin or ibuprofen? Please list medication, dosage and condition _____
YES NO Do you have skin problems or allergies? Please describe _____
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 describe _____
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 infectious 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 diagnose 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 it 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** _____

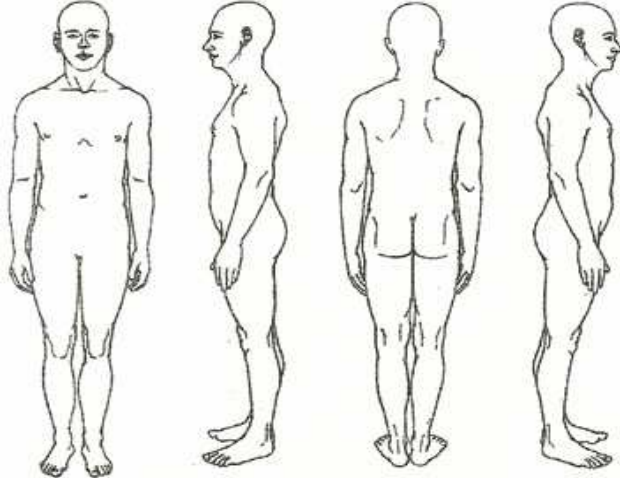
Daily Health Report

PLEASE PRINT

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Please identify current symptoms of muscle or joint pain (P) stiffness (S) or numbness or tingling (N) on the figures below. CIRCLE the area around each letter representing the size and shape of each location



B. Pain Scale: On a scale of 1-10
(1=no pain and 10=unbearable pain
What level is your pain today?

1]-----[10

Activities Scale: On a scale of 1-10
(1=CAN do anything you want
and 10= CANNOT do anything)

What limitations are you experiencing today?

1]-----[10

C. Comments:

Client Signature: _____ Date: _____

FOR THERAPIST USE ONLY

S: SYMPTOMS: LOCATION/INTENSITY/ONSET/
FREQ/DURATION

Massage/ 97124
1 2 3 4 5 6

HOT/COLD/97010
1 2 3 4 5 6

RX
of _____

O: FINDINGS VISUAL OR PALPABLE

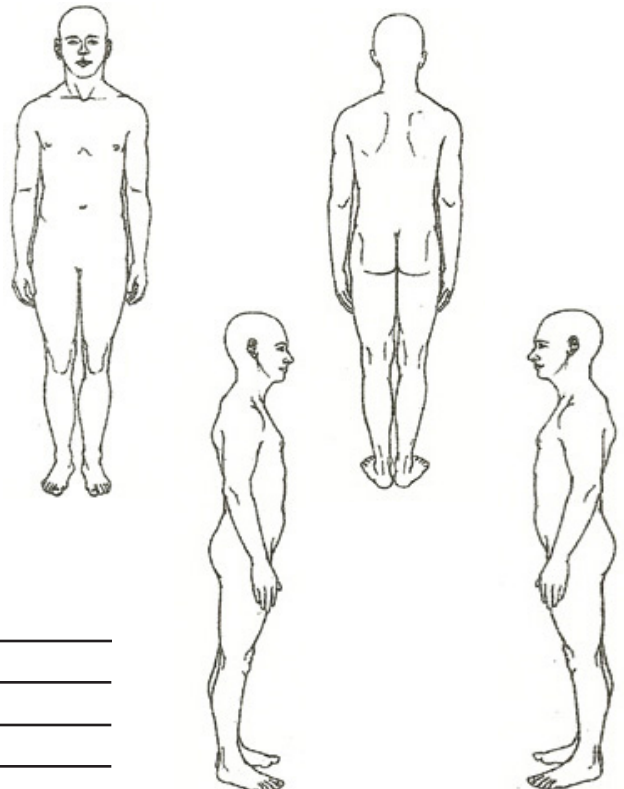
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP
R	L	BL	_____ Δ _____	ADH	HT	TP

A: DT ___ FBSW ___ MLD ___ XXF ___ MFR ___ OTHER _____

P: Cont as RX ___ 1x/ wk for ___ 2x/wk for ___ PRN

COMMENTS: _____

LMP SIGNATURE _____ DATE: _____





Patient Insurance and Injury Data

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Massage Therapist: _____

Patient Information

Name: _____

Address: _____

Phone, Home: _____ Work/Cell: _____

SS# _____ DOB _____ Age: _____ Sex _____ Marital Status _____

Condition is related to: employment or auto accident or other: _____

For Worker's Compensation cases, employer at time of injury: _____

Current employer: _____ Phone _____

Address (with city, state and zip): _____

Employed: Full Time or Part Time (circle one)

Injury Information

Was injury caused by accident or gradual onset? _____ Date of injury _____

Date of first Dr. Appt. _____

Any dates unable to work? Yes or No From ___/___/___ To ___/___/___

Emergency-room visit? Yes or No Date ___/___/___

Hospitalization? Yes or No From ___/___/___ To ___/___/___

Prescribing Physician _____ Physician ID #: _____

Number of visits prescribed by doctor? _____

Insurance Information

Insurance Company: _____ Phone: _____

Address (city, state and zip): _____

Name of Subscriber (if different from patient): _____

Subscriber's ID # _____ Group/Policy #: _____ DOB _____

Patient's relationship to subscriber:

_____ Self _____ Spouse _____ Child _____ Other: _____

Secondary Insurance Coverage (if applicable)

Insurance Company: _____ Phone: _____

Address (city, state and zip): _____

Name of Subscriber (if different from patient): _____

Subscriber's ID # _____ Group/Policy #: _____ DOB _____

Patient's relationship to subscriber:

_____ Self _____ Spouse _____ Child _____ Other: _____

Attorney Information (if applicable)

Firm Name _____ Lawyer Name _____

Address (with city, state and zip): _____

Phone # _____ Fax # _____ Email _____

Case # _____

Incase of emergency please contact: _____