

Advance Therapeutics
2795 152nd Avenue NE Redmond, WA 98052
4600 Union Bay Place NE, Suite B Seattle, WA 98105
Phone: 206.799.1402 Fax: 425.898.0728
www.advancetherapeutics.net

Name: _____ Birth Date: _____
Address: _____ City: _____ State: ____ Zip: _____
Home phone: _____ Mobile phone: _____
E-mail: _____
Primary Physician: _____ Phone: _____
Health Insurance: _____ Policy#: _____ Group#: _____
Emergency Contact: _____ Phone: _____

Employer: _____ Phone: _____

Occupation: _____

Briefly describe your usual activities related to:

Your job: _____

Recreation: _____

Relaxation/stress relief: _____

On average, how many hours of sleep do you get each night? _____ Do you sleep soundly?: _____

Please list any medications you took today: _____

Are you currently under a physicians care for any condition or injury? Yes ___ No ___

If yes, please describe: _____

Do you currently have, or have you ever had: ___ Osteoporosis, arthritis, spinal problems
___ Sprains, strains, broken bones ___ Low back, neck, shoulder or joint pain
___ Tendonitis, bursitis, carpal tunnel syndrome or thoracic outlet syndrome
___ Contagious skin conditions or rashes ___ Heart, kidney, liver or circulatory problems
___ Any other health conditions that I should be aware of in providing massage care? _____

Please see the reverse for important information about your privacy rights under Federal HIPPA regulations.

Signed: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you is collected and used. **Please read it carefully.**

We are committed to collecting, using and sharing your protected health information responsibly. Each time you visit us, a record is made containing your comments, our assessments, treatment delivered and plans for future care. This information serves as the basis for your care and as a means to effectively communicate about your condition and the care delivered.

We may share this information with other health care providers, your insurance company, attorneys involved in a legal proceeding or with others who have a legal claim to such information. **Your personal health information will ONLY be released after you have signed an ‘Authorization to Release Health Information’ with this office, or if we receive authorization, signed and dated by you, from a third party requesting us to release your personal health information to them.** You may revoke an authorization to release your health information at any time. In this event, no further information will be released. The only exception to these statements is where we are legally obligated to release information, in which case you will be notified

You have specific additional rights under law related to the use of your personal health information. If you would like more information regarding our practices or your rights, please contact us by phone or in writing at:

Performance Massage and Bodywork (206) 799-1402
4600 Union Bay Place NE, Suite B Seattle, WA 98105

Initials: _____ Date: _____

CONSENT TO RECEIVE CARE

It is my choice to receive massage therapy and I hereby give my consent to receive care. I have accurately provided all health information requested on the opposite side of this form and agree to report any changes in my condition including but not limited to the effects of the care I receive in this clinic.

I understand that massage therapists do not diagnose illness or disease, nor do they prescribe medical treatment or drugs. I acknowledge that I will seek the care of a primary care physician or other health care professional for those services.

My massage therapist may recommend specific stretches, strengthening exercises, applications of heat or cold packs and postural or functional changes intended to enhance the care which I receive in this clinic. It is my responsibility to follow these recommendations and integrate them into my life in a way that benefits me and does not cause me harm.

If I have questions or concerns about the care which I am receiving, I will express them to my therapist or to a designated clinic supervisor.

Initial: _____ Date: _____

FINANCIAL RESPONSIBILITY

I acknowledge my financial responsibility for the care received in this clinic. Furthermore, I agree to provide timely payment for all services received except as they are covered by medical insurance, a personal injury claim or a state worker’s compensation claim. In the event that my care is covered by medical insurance, I agree to provide timely payment of all care necessary to meet my medical deductible and any co-pays provided for under the terms of my health insurance.

Initial: _____ Date: _____