Alliance THERAPY & CHIROPRACTIC
www.aptwy.com

Rock Springs Clinic
1977 Dewar Drive Suite J
(307) 382-3228 Phone

Green River Clinic
520 Wilkes Drive Suite 17
(307) 875-1788 Phone

Lyman Clinic
109 S Main Street Suite D
(307) 787- 3278 Phone

Massage Intake

Patient History

Patient Name: Date of Birth: Sex: □ M □ F Email:

Billing/Mailing Address: City: State: Zip:

Home Phone: Emergency Contact: Relationship to Patient: Telephone:

How did you hear about us?

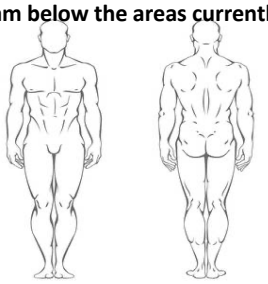
□ Physician □ Internet Search □ Returning Patient □ Word of Mouth □ Other_____

Health History

Please mark if you currently have/had any of the following:

□ Alzheimer's
□ Cardiovascular Disease
□ Cauda Equina Syndrome
□ Cerebral Vascular Accident
□ Current Infection
□ Diabetes Mellitus Type 1 or 2
□ Epilepsy/Seizures
□ Rheumatoid Arthritis
□ History Of Cancer
□ Huntington's
□ Immunosuppression
□ Parkinson's
□ Muscular Dystrophy
□ Lung Disease/Problems
□ Osteoarthritis
□ Stroke
□ Asthma/Allergies
□ Hepatitis
□ Thyroid Problems
□ Currently Pregnant
□ Pacemaker
□ Heart Disease/Problems
□ Obesity
□ Lupus
□ High Blood Pressure
□ Traumatic Brain Injury
□ Fibromyalgia
□ Fracture Or Suspected Fracture
□ Circulation/Bleeding Problems

Mark on the diagram below the areas currently affected by your condition



What treatments have you already received for your condition?

□ Surgery □ Chiropractic
□ Physical Therapy □ Other

Please list past surgeries and dates:

_____

_____

_____

: Consent to Treatment: I understand that the massage therapist is providing massage therapy services within their scope of practice as defined by the American Massage Therapy Association. I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including assessments, examinations and techniques, which may be recommended by my therapist. The therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing.

: Massage Termination: Only professional massage services for therapeutic purposes are offered. Massage services will be terminated immediately in the event of inappropriate conduct of any kind. This includes harassment, threatening speech or behavior, sexual advances or requests, or disrespectful actions or language. A session will not be conducted if the client is under the influence of drugs or alcohol. If the massage is terminated for any of these reasons, full payment for the scheduled session is still required.

: Financial Responsibility and Assignment of Benefits:
I understand and agree that, I am ultimately responsible for the balance of my account for any professional services rendered. If I choose to not pay any outstanding balance, I could be responsible for court costs and attorney's fees, and interest charges of 1.5% monthly or 18% annually on any outstanding balance not paid that is sent to small claims court. In the event of collection procedures, attorney fees and court costs are your responsibility. ***I also understand that the delinquency fee with regards to collections will be equal to 50% of the principal amount owed.***

1. **Workers Compensation Claims:** We submit claims to workers compensation. However, if we received subsequent denials, you will be responsible of the total amount of charges.
2. **Self-Pay Policy:** Payment is due at the time of service.

Massage Therapy					
30 min	$40	60 min	$75	90 min	$115

3. **Auto Claims:** We submit claims to auto insurance. However, if benefits are exhausted or they pay you first you are responsible for the service charges.
4. **Cancellation/No Show Policy:** We require a 4-hour notice in the event of a cancellation. A cancellation fee of 50% will be charged to the *credit card on file* if not given a 4 hour notice.
5. **Arrival:** Arrive 10 minutes early. Promptness is expected for all appointments. In the event of lateness, the massage may be cut short due to other commitments of the therapist.

I certify that I have read this form and understand its contents.

_____ _____

Patient/Parent/Guardian Signature Date