HISTORY/INTAKE FORM

PAGE ONE

PATIENT:			
Address:		State:	Zip:
Date of Birth:	Home Phone:		
Occupation:	Work Phone:		
How Long:	E-mail:		
Spouse:	Spouse wk phone:		

INSURANCE

Date of Incident:	GROUP:
CLAIM/POLICY #:	REF BY:
Soc Sec Number:	Adjuster:

DOCTOR

Name:	
Phone:	
Address:	
City:	
State:	Zip:

LAWYER

Name:	
Phone:	
Address:	
City:	
State:	Zip:

EMPLOYMENT INFORMATION

Company:			
Phone:	Supervisor:		
Address:	City:	State:	Zip:
Notify/Emergency:	Phone:		
Nearest Relative, not living with you?			

PAYMENT INFORMATION

You must check at least one form of payment.

☐ Auto Insurance ☐ Workers Compensation ☐ Major Medical

☐ Attorney Lien ☐ Credit Card ☐ Check

☐ Cash ☐ Other:_____

HISTORY/INTAKE FORM

PAGE TWO

- Was this case related to ? ☐ Work ☐ Auto ☐ Other Explain:_____

- How did it happen? _____

- If it happened at work, was the employer notified? ☐ Yes ☐ No

- Has the insurance company been notified? ☐ Yes ☐ No

- Are you presently employed? ☐ Yes ☐ No

- If work related are your currently working for the same employer? ☐ Yes ☐ No

- Occupation: _____

- Are you presently under a Doctors care? ☐ Yes ☐ No

- Have you ever been treated for the same condition? ☐ Yes ☐ No

- Were you admitted to the hospital? ☐ Yes ☐ No

- Have you had surgery in the past 4 years? ☐ Yes ☐ No

- Are you a smoker/Use alcohol/Use excessive caffine? ☐ Yes ☐ No

- Do you have any preexisting conditions that relate to the present injury? ☐ Yes ☐ No

Have you ever had a Professional Massage before? Yes_____ No_____

Are you currently taking any medications at this time? Yes_____ No_____

If yes, please list medications you are taking:_____

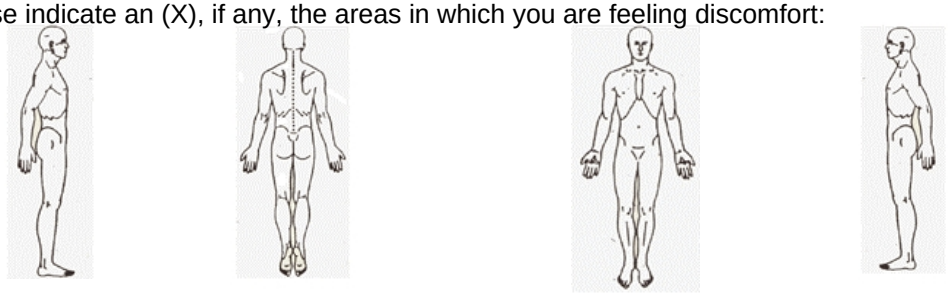
_____

_____

Please review this list and check those conditions that have affected your health either recently or in the past 3 years. Please check all that apply.

____ arthritis
____ diabetes
____ diverticulitis
____ headaches
____ heart conditions
____ back problems
____ high blood pressure
____ insomnia
____ muscle strain/sprain
____ pregnancy
____ scoliosis
____ seizures
____ whiplash
____ chemical dependancy (alcohol, drugs)
____ depression/panic disorder
____ blood clots
____ broken/dislocated bones
____ bruise easily
____ cancer
____ chronic pain
____ constipation/diarrhea
____ auto-immune condition
____ hepatitis (A/B/C, other)
____ skin conditions
____ stroke
____ surgery
____ TMJ disorder

Do you have any allergies to nuts, skin care products, or medications? Yes _____ No _____
Are you wearing: _____contact lenses _____ hearing aids _____hairpiece
Please indicate an (X), if any, the areas in which you are feeling discomfort:



Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment. It is our policy not to have you sign each time you come in for treatment but these rules apply for each visit.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.
4. It is your responsibilty to notify us of any medical, billing or address changes upon the initial greeting with your therapist.

Signature:_____ Date:_____

Release Of Records / Payment Agreement And Assignment of Benefits

Patient to sign prior to any medical treatment to be performed

Patient: _____

Insurance Company: _____

Physician Refferal: _____

Attorney (If applicable): _____

I hereby authorize: NewAgeTouch, My Health Care Provider/Facility, to release any and all medical information to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to NewAgeTouch, for charges not covered by this assignment, including deductibles and co-payment requirements by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and/or court costs, and reasonable legal fees, should this be required. I understand if my commercial insurance has not been paid the bill within 60 days of my visit(s), for my services received by my provider/facility, I am responsible, and I will then make whatever arrangements are necessary and available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assign to NewAgeTouch, my Health Care Provider/Facility, all money to which I am entitled for medically related expenses, received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility/health care provider, received by the insurance copmany, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) NewAgeTouch are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statue or Workers Compensation Statue. Any copy of this document shall be valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement, and hereby acknowledge that I understand it. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Signed: _____ Date:_____

Witness:_____ Date:_____

AUTHORIZATION FOR DIRECT PAYMENT OF INSURANCE BENEFITS TO MEDICAL PROVIDER

Release of Records and Payment agreement

I HEREBY AUTHORIZE and direct you, _____, my Insurance Company, to pay by check, made payable to, and mailed directly to: NewAgeTouch at 240 Ridgewood Ave Holly Hill FL 32117 any of the medical and professional expenses allowable and otherwise payable to me under my current insurance policy, as payment toward the total charges for professional services rendered by NewAgeTouch and or its employees or therapists associated with this case. This payment will not exceed my indebtedness to the above mentioned medical service provider. I understand, that I remain personally liable for, and agree to pay in a timely manner, any balance due, if in fact insurance company does not pay, for whatever reason. I further understand that such payment due from me, and payable by me, is not contingent upon any settlement, claim or verdict by which I may recover said fee.

If my current policy prohibits direct payment to my medical service provider, then I hereby instruct and direct you to make the check payable to me:

Name:_____ and NewAgeTouch, and mail it as follows:

Patients Name C/O NewAgeTouch, 240 Ridgewood Ave Holly Hill FL 32117

Futhermore, I authorize the above mentioned medical services office to, and hereby give power of attorney to, said office to endorse/sign my name on any and all checks for payment of medical services received from my insurance company for medical services provided by said office.

I also grant a lien to said medical services provider for any proceeds or insurnace benefits payable under my policy. A photocopy of this instrument shall be considered as effective and valid as the original.
I also authorize the release of any information pertinent to my case to the insurance company and its adjuster, to my medical providers, or my attorney, to the extent necessary, to obtain payment for medical services. All previous assignments, authorizations, and records release agreements entered into between the parties are hereby rescinded, repealed and otherwise null and void as if never entered into, effective immediately. This instrument is not intended to operate as an assignment as that term is used in Florida Statues 627.736. And any provision(s) of this instrument that may be interpreted as such shall be considered null and void from the beginning and the remaining provision(s) of this instrument may be severed from said provision(s) and will remain in full force, effect, and operation.

Executed this 18 Day of October , 2017

Witness:_____ Date: _____

CLAIMANT:_____ Date: _____

Provider or Representative:_____

UNDERSTANDING INSURANCE AND PAYMENT AGREEMENT REGARDING INSURANCE PAYMENTS

I understand that my insurance contract is an agreement between the insurance company and me. I acknowledge that your office is willing to prepare the necessary bills and reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment.

I acknowledge and agree, that I am ultimately responsible to you for payment of any balances due, including unpaid deductibles co-pays and/or unpaid percentage amounts due to you according to my policy coverage. This goes as well as for any outstanding amounts due in the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney letter of protection or lien on my behalf. I understand that I will be billed for any fees, co-pays and deductibles at the time of visit, for services rendered that day, if that amount is known at the time of visit. Should the deductibles and/or co-pays not be known at the time of visit, I agree to pay for these amounts due as soon as I am notifed either by my insurance company or by your office.

I will also be responsible to you for any fees that my insurance company refuses to ay, no matter what the reason after all efforts are made by your office to collect from them on my behalf.

Patient Name:_____

Signature: _____ Date: _____

I elect to pay for co-pay and or deductibles by: select one of the following.

☐ Cash ☐ Credit Card ☐ Local Check

Signature: _____ Date: _____

REGARDING ATTORNEY LIENS

I understand that if I have an attorney involved in my case, and/or if there is no settlement or an incomplete settlement to cover my outstanding bill with your office, I will accept responsibility for the amounts due to you. I then agree to pay or to make payment arrangements as soon as I and/or you are notified of the outcome of the settlement.

I understand that as long as the attorney is working on my case, prior to final settlement, that you agree not to submit any bills to me or in anyway request payment from me for services. If and when, I have need of an attorney, now or in the future, I agree to also sign an Attorney Letter of Protection for my attorney to sign and return to your office if and when necessary. I understand this letter is necessary to protect your bills in the event there is a settlement.

Signature: _____ Date: _____