Federal Way Muscular Therapy, Inc.
33650 6th Avenue South Suite 100, Federal Way, Washington 98003
Phone (253) 942-3303 Fax (253) 815-8805

Please Check Your Billing Preference:

☐ **Health Insurance** ☐ **Motor Vehicle Insurance** ☐ **Work/L&I injury** ☐ **Out-of-Pocket**

Patient Registration

Name: _____ Date of Birth: _____/_____/_____

Mailing Address: _____ City: _____ Zip: _____

Physical Address: _____ City: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Please Circle One Gender: M F Status: S M D W

Employer: _____ Phone: ( ) _____

Address: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

Referring Doctor or Provider _____ Phone: ( ) _____

Please answer the following questions:	**Yes**	**No**
Have you ever had a professional massage before?	____	____
Do you have any infectious or contagious disease?	____	____
Do you wear contact lenses?	____	____
Do you have any skin problems or allergies?	____	____
Do you have varicose veins or blood clots?	____	____
Do you have high blood pressure?	____	____
Do you have arthritis?	____	____
Do you have any heart problems?	____	____
Do you exercise regularly?	____	____

If Yes, how much and what kind? _____

Are you pregnant? If so, what stage? _____

Have you ever had surgery? If yes, please describe: _____

Are you on any medications? If yes, please explain: _____

Do you have any other medical condition that your practitioner should be aware of before you receive massage?

_____

Please READ and INITIAL each of the following paragraphs:

Purpose of Massage:

_____ I understand that the purpose of massage is given for stress reduction, relief from muscular tension, spasm or pain; or, for increasing circulation or energy flow. I understand that the massage practitioner does not diagnose illness, disease, or any other physical or mental disorder, nor do they perform spinal manipulation. 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 that I might have.

_____ I understand that sometimes there are changes to the schedule and that if the licensed massage practitioner I chose is sick or unable to work, I will be moved to another practitioner for that massage. All of our LMPs are highly skilled.

Financial Consideration:

_____ Please note that in the event that you fail to make payment when due past 90 days, this account will be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

_____ I understand that if I cannot keep my appointment and do not give at least **24 hours notice, I will pay a $45.00 Fee**

_____ I understand that co-pays are due at time of service.

_____**Prescriptions or referrals are required to bill insurance. I understand that it is my responsibility to make sure I have one at the time of service. I also understand it is my responsibility to keep my prescription/referral up to date and current. If my insurance denies payment because of missing or expired prescriptions, I will be responsible for all charges.**

Signature: _____ Date: _____

Federal Way Muscular Therapy, Inc.

Specializing in soft tissue injuries

Health Insurance Information

PLEASE ONLY FILL OUT THE RELATIVE INFORMATION

Please provide referral or prescription at first appointment

Primary Insurance Carrier: _____ Phone Number: (_____) _____

Subscriber or Member Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN: _____ Employed By: _____

Secondary Insurance Carrier: _____ Phone Number: _____

Subscriber of Member Number: _____ Group Number: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber SSN: _____ Employed By: _____

Auto Insurance Information

Personal Injury Protection (PIP)

Insurance: _____ Adjuster Name: _____

Phone: ( ) _____ Claim Number: _____

Policy Number: _____ State where accident occurred: _____

Date of Injury: _____/_____/_____ Estimated Damage: _____

****Third Party Claims are not accepted unless approved by management. Please consult with receptionist****

Work Injury Information

Please provide copy of claim form

Must have order for massage up to 6 visits allowed / Authorization needed after 6 visits

Is claim Federal: _____ State: _____ Private: _____ Date of Injury: _____/_____/_____

Claim Number: _____ Company: _____

Claim Manager Name: _____ Phone: ( ) _____

Billing Address: _____ City: _____ State: _____ Zip: _____

Patient's Agreement

All of the above information is true to my knowledge. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in the collection of funds from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I understand that I am responsible for any and all charges my insurance does not pay. I also agree to pay any collection or attorney fees that should arise from nonpayment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered will be immediately due and payable.

Patient Signature:_____ Date: _____

Guardian Signature:_____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD

I have been given a copy of Federal Way Muscular Therapy "Notice of Privacy Practices".

_____ I do **NOT** have any questions

_____ I do have questions and would like the Privacy Office to contact me.
Phone Number to contact: _____
Best time to call: _____

Printed Name: _____

Patient Signature: _____ Date: _____

Notice given, but no signature _____

Reason:_____

_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accounting Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your information.

With specific written authorization, we are permitted to use and disclose your healthcare records for the purpose of treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- Payment means such as activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, treatment information is disclosed when billing a health plan for your health care services.
- Health Care Operations include the business aspects of running our clinic.

Unless you request, we may use or disclose health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments, send postcards, and/or leave messages at home and/or at work. Any other uses and disclosures will be made only as permitted by HIPAA regulations, or with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a writing request to our Privacy Officer at the practice office listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, relatives, close personal friends or any other person identified by you. We are, however, are not required to agree to a request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The rights to access, inspect and copy your protected health information.
- The right to receive an accounting of disclosures of protected health information outside treatment, payment and healthcare operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with a notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective April, 14, 2003 and we are required to abide by the terms of the privacy practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted.

You have the right to file a formal, written complaint with us at the address below or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against your for filing a complaint.

For more information about our Privacy Practices please contact:
Teresa Fromm, Privacy Officer
Federal Way Muscular Therapy
33650 6th Avenue South Suite 100
Federal Way, WA 98003
(253) 942 3304

For more information or to file a complaint:
The U.S Department of Health & Human Services
200 Independence Avenue, S.W.
Washington D.C. 20201
877-696-6775 (toll free)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____