

Name _____ Today's Date _____

Complete Home Address _____

Home Phone _____ Work/Cell Phone _____ Date of Birth _____

Marital Status _____ Number of Children _____ Email Address _____

Pregnant or Nursing Now _____ Miscarriages or Terminations & dates _____

Glasses _____ Contacts _____ Denture or dental appliances _____

Occupation and what you **physically** do at work _____

When was your last massage or Roling session? _____ How did you hear about us? _____

What do you do for pain management? _____

If you are currently being treated by a doctor for something specific, please explain and give doctor's name and specialty: _____

Please list ALL **vitamins, mineral, herbs, homeopathics, and medications** you are currently taking and why: _____

If you have pain: **When** did it start? What **caused** it? **Where** is it? How often do you feel it? On a 1-10 scale (10 being highest), indicate the **location(s), intensity, & type** of pain (dull, sharp, deep, superficial, shooting, tingling, burning etc.):

List all previous **injuries, injections, and surgeries** and give approximate dates: _____

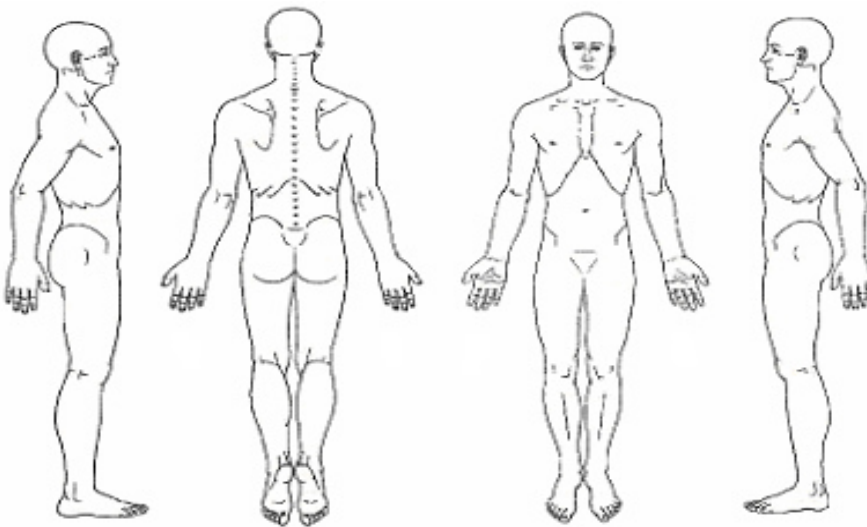
	Quantity	Frequency
Coffee/Tea		
Soda		
Chocolate		
Sugar		
Alcohol		
Tobacco		
Water		

Type of exercise	Frequency

Please **CHECK** all areas of **pain, injury, or health condition** that apply:

- Headache
- Neck
- Shoulder
- Upper back
- Mid back
- Low back
- Hip
- Leg/knee
- Ankle/foot
- Arm/hand/wrist/fingers
- Joint pain/immobility
- Numbness/tingling
- Muscular cramps
- TMJ dysfunction
- Night guard/splint
- Arthritis/bursitis
- Scoliosis
- Fibromyalgia
- Sciatica
- Constipation
- Allergies
- Stress
- Nervousness/anxiety
- Depression
- Sleeping difficulties
- Heart disease
- Diabetes
- Cancer/ tumors
- MS or CP
- Phlebitis/history of blood clots
- Open sore/wound
- Menstrual problems
- Varicose veins
- Skin problems
- Contagious health/skin condition
- Orthotics
- Implants (what type/location)
- Other health condition(s) (please list)

Please **SHADE** all areas of pain patterns, discomfort, and stiffness:



Body Balance Roling and Massage, LLC

Client agreements

PRIVACY POLICY:

I acknowledge that I have received Body Balance Roling and Massage LLC's Notice of Privacy Policy (also posted on website). I understand that protected health information may be disclosed or used for treatment, payment, or health care operations. I understand that I have the right to request a restriction as to how my protected health information is used or disclosed. Body Balance Roling and Massage LLC is not required to agree to this restriction, but if we do so, we shall honor that agreement. Body Balance Roling and Massage LLC reserves the right to change the Notice of Privacy Policy.

_____ (initial)

COMMUNICATION:

Body Balance Roling and Massage, LLC may leave a message on my home answering machine/voice mail or cell phone as provided on my Health Intake Form.

_____ (initial)

Medical information may be provided to the following person(s):

_____ Name of contact person other than patient

_____ contact information – phone/email

CANCELLATION POLICY:

All cancellations must take place at least 24 hours before the scheduled appointment time in order to avoid the cancellation fee of \$65.00. Please be respectful of everyone's time and allow us enough time to book someone else if you cannot make your scheduled appointment. Multiple last minute cancellations will result in future scheduling requests being denied.

Session start and end times are firm. Please arrive on time for your scheduled appointment.

I agree to all of the above regarding privacy, communication, and cancellation policies:

_____ Print Patient Name

_____ Date

_____ Signature of Patient or Personal Representative

_____ Relationship to Patient (if other than patient)

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CONSENT TO TREAT:

I fully understand that the purpose of Roling is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct manipulation of the soft tissues of the body and includes ongoing education for the purpose of achieving and increase in support and adaptability in the body. However, I understand that Jenny Rock, Certified Rolfer makes no warranties or guarantees regarding the specific results of the Roling process in my body.

I understand that neither Roling nor massage are involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed. Neither the Certified Rolfer™ (Rolfing) nor the licensed massage therapist (LMT) claim to treat, prescribe or diagnose any illness, disease, or any other physical or mental disorder. Nothing said or done by the Rolfer or LMT should be misconstrued to be such.

I hereby consent to and authorize the LMT or Rolfer to conduct such physical examinations and perform such assessments and treatment as the deemed necessary and appropriate. I understand it is necessary for the Rolfer or LMT to physically contact my body in order to treat me. Should treatment be performed, the LMT or Rolfer will fully inform me as to the nature of the procedure, the alternatives to treatment, the risks that are involved, and that I will be given the opportunity to ask questions and have my questions answered.

I **DO/DO NOT** consent to medical photographs to be taken of me (or a person for whom I am legal guardian). I understand that the information may be used in my medical records and refusal to consent will in no way affect the care I will receive.

I **DO/DO NOT** consent to intraoral work when applicable, recognizing that the therapist will be wearing gloves and is properly trained.

I agree to the consent to treat policies described above:

Print Patient Name

Date

Signature of Patient or Personal Representative

Relationship to Patient (if other than patient)

Health Insurance

Legal name	Today's date
Complete mailing address	
Home phone	Work/cell phone
Date of birth	Personal email address
Insurance company name	
Policy #	Group #
Complete claims billing address	
Customer service phone #	Provider phone #
Insured's name (if different from patient)	Relationship to patient
Insured's date of birth	Insured's phone #
Insured's complete address	

As a courtesy, Body Balance will verify and bill your insurance coverage for outpatient therapy services for all services rendered. Deductibles and co-payments are your responsibility.

FINANCIAL RESPONSIBILITY: For and in consideration of the treatment to the patient, I promise to pay all charges for services rendered to or on behalf of the patient. If the assigned insurance denies payment, I promise to pay the balance due upon notification. Any unpaid balance that is over 60 days old will be referred to Collections for accounts receivable assistance. I will bear the cost of collection and/or court costs and reasonable legal fees should this be required.

ASSIGNMENT OF BENEFITS: I authorize my insurance/benefits carrier(s) to remit payment of benefits for any claim to Body Balance Roling and Massage LLC's. I understand that any ineligible/not covered charges are my responsibility. I authorize Body Balance Roling and Massage LLC's to release any information necessary to process medical claims.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered to be as valid as the original. I have read, understand, and agree to the above.

Signature

Date