



**Contact Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone #s: Hm. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Wk: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Mobile: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Email: (Required) \_\_\_\_\_ (We provide appointment confirmations via email.)  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_ Sex:  M  F Marital Status:  S  M  D  
 Drivers License #: *Please be prepared to show your drivers license to verify your information. Thanks!*  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Injury Treatment?  Y  N If Yes, date of Injury: \_\_\_\_\_  Auto  Work  Other \_\_\_\_\_  
 Referring Physician: \_\_\_\_\_ Ph #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ **LLM Staff: New?**  Y  N  
 Referring Patient/Client: \_\_\_\_\_ Other Referral: \_\_\_\_\_

**Insurance Information**

Insurance Type:  Health/Medical  Automobile  L&I/Workers Compensation  
 Primary Insured's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  Full Time  Part Time  
 Relationship to Insured:  Self  Spouse/Domestic Partner  Dependant  
 Health Ins. Co. Name: \_\_\_\_\_ Member ID #: \_\_\_\_\_  
 Health Plan Name: \_\_\_\_\_ Group ID #: \_\_\_\_\_ Copay Amt: \_\_\_\_\_  
 Auto or L&I Ins. Co Name: \_\_\_\_\_ Claim #: \_\_\_\_\_  
 Ins. Contact/Adjuster: \_\_\_\_\_ Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_  
 Ins. Co. Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_ Zip: \_\_\_\_\_  
 Attorney Name: \_\_\_\_\_ Phone #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Ext. \_\_\_\_

**Acknowledgements**

- I acknowledge that the above information is complete and accurate to the best of my knowledge. I will notify Living Lotus Massage and/or treating LMP of any changes in my physical condition or any changes in the information on this form prior to any additional treatment.
- I agree to the release of treatment notes and/or billing information to my other healthcare providers and my insurance companies.
- I agree that I am fully responsible for all health care bills for services rendered and that payment is not contingent on any settlement, judgment or insurance payment. Balance is due 90 days from the date of service, and any outstanding balances incur a 1% per month compound interest charge. Past due accounts over 90 days may be subject to a \$15 re-billing fee. We will initiate collection procedures if no payment is made on your account for 120 days. You will be responsible for payment of reasonable attorney fees, collection agency fees, and any court costs incurred to collect your account.
- I understand that appointments cancelled less than 24 hours prior to the scheduled appointment time will be subject to a charge equal to 50% of the massage service booked. Appointments not kept will be charged 100% of the massage service booked. Even if the appointment was a Medical Massage appointment, you will be responsible for payment out-of-pocket (your insurance company will not pay for your missed appointment).

**Patient or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



General Conditions History

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Place a checkmark beside the conditions you are currently experiencing.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> HIV/Aids             | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sciatica          |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Stiff Joints      |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Allergies    |
| <input type="checkbox"/> Athletes Foot        | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Sprains/Strains   |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Disc Problems         | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Back Pain            | <input type="checkbox"/> Diverticulitis        | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Swollen Feet/Legs |
| <input type="checkbox"/> Bone Fractures       | <input type="checkbox"/> Eczema                | <input type="checkbox"/> Muscle Spasms       | <input type="checkbox"/> Tendonitis        |
| <input type="checkbox"/> Bursitis             | <input type="checkbox"/> Epilepsy/seizures     | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Tingling          |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Excess Stress         | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Tumors            |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Psoriasis           | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Rashes              | <input type="checkbox"/> Whiplash          |
| <input type="checkbox"/> Colitis              | <input type="checkbox"/> Heart Attack/Ailments | <input type="checkbox"/> Ringworm            | <input type="checkbox"/> Other _____       |
|   | <input type="checkbox"/> Hemophilia            |  |  |

For Women Only

Pregnant ( Weeks)  Trying to get Pregnant  Menopause  PMS  Excessive Bleeding  Amenorrhea

Accident, Injury, Surgery, Medication & Miscellaneous Information

Accident or Injury (0 - 2 years ago): \_\_\_\_\_

Accident or Injury (3 - 5 years ago): \_\_\_\_\_

Accident or Injury (Over 5 years ago): \_\_\_\_\_

Are you currently receiving medical or chiropractic care?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you currently taking medications (prescription or over-the-counter)?  Yes  No

If yes, please explain: \_\_\_\_\_

Are you wear contact lenses?  Hard  Soft  Neither

Lifestyle Factors

Explain your work and home daily activities (Weekdays and weekends):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any exercise activities: \_\_\_\_\_

Frequency of exercise: \_\_\_\_\_ Have you received massage before?  Yes  No

If Yes, please share what you liked or disliked about previous massage sessions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### General Symptom(s) Description

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Describe your current condition: \_\_\_\_\_

How did the condition begin? \_\_\_\_\_

\_\_\_\_\_ Date problem began? \_\_\_\_\_

What makes the condition better? \_\_\_\_\_

What makes the condition worse? \_\_\_\_\_

Any range of motion restrictions? \_\_\_\_\_

Have you received any treatment(s) for this condition? \_\_\_\_\_

### Specific Symptom(s) Description

How severe is your pain? (Circle)      No Pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Unbearable

How often are your symptoms present?     Constantly    Frequently    Occasionally    Intermittently

Describe your current symptoms/pain?    Shooting    Throbbing    Dull/Achy    Sharp/Stabbing

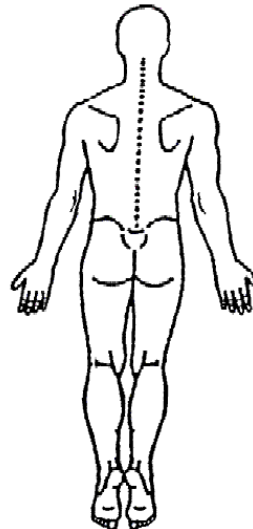
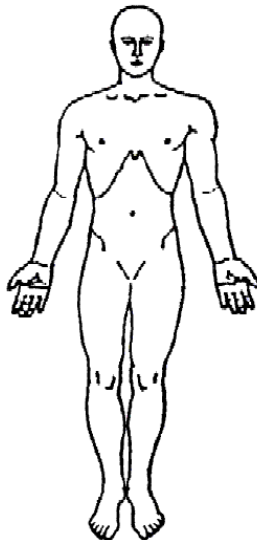
Tingling    Numbness    Burning    Soreness

How is the quality of your sleep? \_\_\_\_\_

What goals do you hope to achieve with therapeutic massage sessions? \_\_\_\_\_

### Symptom(s) Location

1) Draw an X where you feel the pain, tingling, numbness, burning and / or soreness described above.



Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Medical Massage Policies & Rates

### Service Policies

To receive Medical Massage, you **must** present a written prescription for therapeutic massage that includes appropriate diagnosis code(s). In addition, we also prefer to receive a treatment plan provided by your licensed doctor, chiropractor, naturopath, etc.

Medical Massage treatment is provided only for the prescribed area(s) and condition(s) diagnosed by your licensed medical professional (doctor, chiropractor, naturopath, etc.). If you request massage unrelated to your prescription (not covered by your insurance), you will be responsible for full payment of those massage charges.

Medical Massage:

- β Requires the application of advanced knowledge and skills.
- β Requires continued communication with you, the referring doctor(s), insurance company(ies), and maybe your attorney(s).
- β Requires more time to prepare/provide treatment documentation/reports for the doctor, insurance company, attorney etc.
- β Frequently incurs lengthy payment delays resulting from the insurance billing and legal settlement processes.

These additional requirements necessitate a fee schedule for Medical Massage (medical care) which differs from our relaxation massage fee schedule (personal care).

### Medical Massage Fees for Services

97124	Massage Therapy	\$120 per hour (\$30.00 per 15 minute 1 unit)
97140	Manual Massage	\$120 per hour (\$30.00 per 15 minute 1 unit)

If Living Lotus Massage is a contracted provider for your medical health plan, then the Medical Massage fees for service are set by that contract. Those fees may vary from health plan to health plan. It is your responsibility to check with your insurance plan to determine the amount of coverage your plan provides. Be prepared to provide any co-payment and/or coinsurance amount(s) that your insurance plan requires at the time you receive service.

### Payment Policies

Living Lotus Massage (or our billing service) will bill your insurance company directly under the following conditions:

- β **Medical Health Care Plan Coverage:** Verbal verification of coverage
- β **Workers Compensation Claims:** Verbal verification of coverage
- β **Auto Accident Claims \***
  - β **PIP:** Verbal verification of coverage.
  - β **Second Party Coverage:** Written verification of coverage.
  - β **Third Party Coverage:** Signed 3rd Party Coverage policy and letter of guarantee signed by the patient's attorney.

\*A 20% cash / check discount is available if payment for Medical Massage is made in full at the time services are provided.

All insurance account balances are due 90 days from the date of service, and any outstanding balances incur a 1% per month compound interest charge. Past due accounts over 90 days may be subject to a \$15 re-billing fee. We will initiate collection procedures if no payment is made on your account for 120 days. You will be responsible for payment of reasonable attorney fees, collection agency fees, and any court costs incurred to collect your account.

### Office Policies

**If you need to cancel an appointment, please call or email us 24 hours in advance of the scheduled appointment time.** Sudden absences without a cancellation notice hurts our service quality and operation.

Appointments cancelled less than 24 hours prior to the scheduled appointment time will be subject to a charge equal to 50% of the massage service booked. Appointments not kept will be charged 100% of the massage service booked. Even if the appointment was a Medical Massage appointment, you will be responsible for payment out-of-pocket (your insurance company will not pay for your missed appointment).

### Patient Agreement

I have read and fully understand the Living Lotus Massage policies and fees stated above and agree to abide by them.

**Patient or Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_