172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

NEW CLIENT REGISTRATION FORM

Last Name ________________________ First Name _____________________ Middle Initial ________

Today's Date ______/_______/_________

Street Address ____

City ____ State _________ Zip Code _______________

Date of Birth _______________ Age________

Home Phone (_______) _________-______________ Work Phone (______) _________-_____________

Cell Phone (_______) _________-______________

Email Address ____

Emergency Contact Name ___________________________________ Relationship _______________

Phone (_______) _________-______________

Your Employer _______________________________________ Occupation _______________________

Is this visit routine or due to illness or accident or other?

Explain____

If accident please provide date and brief description ____________________________

RESPONSIBLE PARTY INFORMATION

Name of Guardian (Last, First & Middle) ____

Date of Birth ____________________________ Relationship to Client ___________________________

Street Address ____

City ____ State _________ Zip Code _______________

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

Employer ____ Phone (_____)______-___________

Street Address ____

City ______________________________________ State ________ Zip Code _____________

Name of Insurance ________________________ ID # _______________ Grp# ______________

CONTACT PREFERENCE

How would you like us to contact you? Please indicated in order of preference(#1-4)

E-mail____ Home Phone____ Cell Phone____ Work Phone_____

If we cannot reach you, can we leave a message with the office name at your work?
Circle one **Yes** **No**

If we do not reach you, can we leave a message with the office name at your home?
Circle one: **Yes** **No**

Is it OK to leave a detailed message? Circle one: **Yes** **No**
(If No - we will leave a message asking you to call us back, so we can discuss the details we need to share with you).

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following condition:

____ ____/_____/_____

Client's Full Name ________________________________Date of Birth____________ Age____

This authorization will be effective as of ____/_____/_____ and expires on ____/_____/_____

Signature ____________________________________ Witnessed by _______________________
Parent or Guardian

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

Do we have your permission to send an email regarding news in the field or information related to the practice? Circle one: **Yes** **No** (you can opt out at any time).

IMPORTANT!

Please let us know as soon as possible, if your contact information or your insurance has changed. Thank you in advance!

If you need to cancel or re-schedule an appointment, please be so kind to give us a 24 hour notice.

No shows, cancellations or re-scheduling with less than 24 hours notice will be charged as detailed in

Our Financial Policies portion of our intake documentation.

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

OUR FINANCIAL POLICIES

Please, initial each item below. If you have questions, please ask us and we will gladly explain.

_______All references in the following policy: I, me, my, you, your, etc. indicate and refer to the Client seeking services from Active Bodywork And Rehabilitation.

_______ I understand and agree that, Active Bodywork and Rehabilitation requires a valid credit card for scheduling my reservation / appointment.

_______ I understand and agree that full payment is due at time services are rendered.

_______ I understand and agree that unless otherwise specified and agreed upon between me and Advanced Bodywork And Rehabilitation, all services rendered to me by Advanced Bodywork And Rehabilitation are payable *in cash* at time services are rendered. Returned checks will be charged a $35 processing fee.

_______ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me by Advanced Bodywork And Rehabilitation.

_______ I understand and agree that after verification of insurance benefits, Advanced Bodywork And Rehabilitation will accept payment directly from my carrier. Furthermore, client (you) insurance is an agreement between you and your insurance company. Advanced Bodywork And Rehabilitation does not promise that your insurance company will pay all charges relative to your care even after verification has been made. Therefore, all charges disputed by your carrier will be your personal responsibility, to be paid in full by you no more than 60 days from date of notification from your carrier, via a Square Invoice sent by Advanced Bodywork And Rehabilitation.

_______ I agree to pay all *Uncovered Services* at the time of the visit (i.e. deductible, copayment etc.)

_______I agree to pay for all *Products* provided and sold to me by Advanced Bodywork And Rehabilitation at the time of services being rendered to (i.e. deductible, copayment etc.)

_______ I agree that if this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

______ I hereby assign all massage-related benefits, including major medical benefits to which I am entitled, Medicare, Private insurance, and all other health plans to Advanced Bodywork And Rehabilitation

______ I authorize the release of my medical records to third parties requiring these records for determination of financial liability.

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

_______I understand and agree that, *cancellations / reschedules must be made at least 24 hours from appointment*. You (client) can cancel or reschedule online through your confirmation email, or by calling us or texting us.
Please make sure to clearly provide your name and the scheduled appointment date / time to be cancelled as well as your preferred day /time to reschedule - if you have one.

_______I understand and agree that if I am a *late arrival*, I *will not have my treatment time extended*. *Also, I will be charged full price of the scheduled appointment* (discounted price will be used, if it applies based on how the appointment was scheduled).

_______I understand and agree that if I fail to show up for my appointment (*no-show*), *I will be charged my appointment's full price and without discounts. I also understand that, this fee will not be covered by my insurance, if any is available.*
An appointment is considered a no-show after 20 minutes from start time.

_______ I agree and understand that I will be charged 60% of the appointment's price in the event that I provide *less than 24 hours notice* of cancellation (discounted price will be used, if it applies based on how the appointment was scheduled.). I also understand that, this fee will not be covered by my insurance, if any is available.
For example: The client is a no-show for a 60 minute “trial” session that costs $40 (the full price of which is $80), There will be a charge of .60 x $40= $24 for this missed 60 minute session.

_______I understand and agree that, if I have a voucher or gift certificate and *I do not provide a 24-hour cancellation notice* – my voucher / gift certificate will be marked as “used”.

____ Date ______/_______/________
Client Name / Client Signature Date

____ Date ______/_______/________
Guarantor Signature Relationship to Client

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

CONFIDENTIAL CLIENT HEALTH QUESTIONAIRE

Last Name ______________________ First Name ___________________ Middle Initial _______

Today's Date ______/_______/________

How did you find our office?
□Friend □Flyer □Web □Other_____________________

Have you been treated by a massage therapist before?________________________

Please list practitioner names and specialties of your other health care providers:

1. Practitioner / health care provider name & specialty
2. Practitioner / health care provider name & specialty
3. Practitioner / health care provider name & specialty

Do we have your permission to contact them to coordinate your care?
Circle one: □Yes □No

Please, list your medications / vitamins / supplements:

Name / Dose / Duration ____

Name / Dose / Duration ____

Name / Dose / Duration ____

Do you have any diagnosed health conditions? Please provide details.

Please describe your reason for seeking care today, with all the details you want us to address :

___

How did the problem began (if you know): ____

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

Is this problem ☐Work related ☐Auto related ☐Other ________

Does it seem to be getting ☐ Worse ☐ Better or ☐ Staying the same?

It interferes with ☐ Sitting ☐ Work ☐ Sleep ☐ Walking ☐ Hobbies ☐ Leisure ☐Other

Mark current problems - check all that apply:

☐Sharp Pain ☐Stabbing Pain ☐Ache ☐Weak ☐Numb ☐Throbbing ☐Shooting ☐Burning
☐Tingling ☐Decreased motion

What is the frequency of your problem?
☐ Constant (75%-100%) ☐ Frequent (50%-75%)
☐ Occasional (25%-50%) ☐ Intermittent (<25%)

Are your symptoms worse: ☐ In the morning ☐ In the afternoon ☐ At night

Do your symptoms wake you up? ☐Yes ☐No

What makes your problem better?
☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Exercise ☐Rest

What makes your problem worse?
☐Nothing ☐Lying Down ☐Walking ☐Standing ☐Sitting ☐Exercise ☐Rest

Have you experienced a similar problem in the past? ☐ Yes ☐ No
Did you seek care in the past? ☐ Yes ☐ No. From whom? ________________________________

Physical activity at work: ☐ Sitting 50%+ of day ☐Light labor ☐ Heavy labor ☐ Repeated motion

Occupation: ______________________________ ☐FT ☐PT

Has your work changed due to this condition? ☐Yes ☐No

What is your current work status?
☐ FT, no restrictions ☐ PT, no restrictions ☐ Off work due to injury ☐ Unemployed
☐ FT, with restrictions ☐ PT, with restrictions ☐ Homemaker ☐ FT student ☐ Retired

Please circle the current level of discomfort your problem causes you, when it is at its worst
none 1 2 3 4 5 6 7 8 9 10 **worst ever.**

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

Mark current problems on the drawing below: ????

HEALTH HISTORY

Please check all symptoms you have ever had, even if they do not seem related to your current problem

- ☐ Allergies
- ☐ Abnormal weight gain
- ☐ Abnormal weight loss
- ☐ Amenorrhea
- ☐ Amputations
- ☐ Ankle pain
- ☐ Aortic Aneurysm
- ☐ Arhythmia
- ☐ Arm /elbow / wrist pain
- ☐ Asthma
- ☐ Breathing difficulty
- ☐ Bursitis
- ☐ Cancer / Tumor
- ☐ Cataracts
- ☐ Change in bowel habits
- ☐ Chest pain
- ☐ Chronic cough
- ☐ Cold / flu (frequently)
- ☐ Conjunctivitis
- ☐ Constipation
- ☐ Corticosteroid use
- ☐ Currently pregnant
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Fainting / Dizziness
- ☐ Food intolerances
- ☐ Foot pain
- ☐ Frequent urination
- ☐ Glaucoma
- ☐ Heartburn/indigestion
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hip pain
- ☐ Hyper / hypo thyroid
- ☐ Impotency
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney infections
- ☐ Knee pain
- ☐ Leg pain
- ☐ Low back pain
- ☐ Meniere's
- ☐ Menstrual pain
- ☐ Metal / surgical implants
- ☐ Mid back pain
- ☐ Migraine / headache
- ☐ Neck pain
- ☐ Numbness / tingling
- ☐ Osteoporosis
- ☐ Prolapse
- ☐ Prostate problems
- ☐ Rash or hives
- ☐ Scoliosis
- ☐ Serious injuries or trauma
- ☐ Shoulder pain
- ☐ Sinus infection
- ☐ Slow healing
- ☐ Spine injuries / ailments
- ☐ Stroke
- ☐ Surgery / Hospitalization
- ☐ Suspicious mole(s)
- ☐ Tendonitis
- ☐ Tinnitus
- ☐ Ulcers
- ☐ Urinary retention
- ☐ Visual disturbances

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

FAMILY HEALTH HISTORY

If a family member has or had any of the following, please check the box(s):

☐Cancer ☐High Blood Pressure ☐Heart Problems ☐Stroke ☐Diabetes ☐Parkinson's

☐Multiple Sclerosis ☐Fibromyalgia ☐ Autism ☐Other__ _____________

LIFESTYLE

YES Notes, if YES

Do/did you smoke/use any tobacco? _________☐

Do/did you drink alcohol? ☐

Do/did you use drugs? ☐

Do you consume caffeine? ☐

Do you consume sugar / sugary drinks? ☐

Do you eat a lot of vegetables? ☐

Do you eat fast/processed foods? ☐

Do you drink a lot of water? ☐

What is your current level of stress? ☐Little to none ☐Minimal ☐Moderate ☐Severe

General Physical Activity: ☐ No regular exercise ☐ Light exercise ☐ Moderate ☐ Strenuous

Client's Signature ____ Date _____/_____/______

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

PRIVACY POLICY

Please review carefully!

Federal legislation requires that we issue this notice of our privacy practices.

We protect our client's privacy with great care and we diligently follow the applicable laws aimed at protecting the confidentiality of your medical information.

You have the right to confidentiality of your medical information, and we are required by law to maintain the privacy of that information.

This following notice describes how medical information about you may be used and disclosed, as well as how you can get access to this information.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician or other health care professional, our office staff and others outside our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of your health care provider's practice and any other use required by law.
We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law: public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, national security, worker's compensation, and law enforcement.

Treatment
We will use and disclose your health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. We may also share medical information about you to your other health care providers to assist them in treating you.

Payment
Your protected health information will be used, as needed, to obtain payment for your health care services.

Your Rights
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in anticipation of, or use in, a civil, criminal, or administrative action or proceeding. A copy of your records must be requested in writing. You have the right to request a restriction of your protected

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

health information. The physician is not required to agree to a restriction that you request. You have the right to request that we communicate with you about your medical information by different means or to a different location. This request must be made in writing. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. You may request a copy of this notice.

Questions or Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a compliant with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.
By signing below, I acknowledge that I have read, understand and accept the terms of this document.

Signature of Client or Guardian / Date

Print Client Name ______________________________________

Signature ____ Date ______/_______/________

RELEASE OF MEDICAL RECORDS

I authorize the release of medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance case managers, for the purposes of processing my claims.
signature date signature of parent or legal guardian (if client is a minor)
(Please inform your practitioner immediately upon signing any exclusive Release of Medical Records with your attorney that may impact the above release statement.)

Signature of Client or Guardian / Date

Print Client Name ______________________________________

Signature ____ Date ______/_______/________

CLIENT AGREEMENT

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of

172 SE 6th Avenue
Hillsboro, OR 97123
503-888-7975
www.abwrehab.com
office@abwrehab.com

effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status. signature date

Signature of Client or Guardian / Date

Print Client Name ____

Signature ____ Date ______/_______/________