Meridian Medical Massage

Welcome to our health and wellness clinic, we are so glad you are here!

PATIENT INFORMATION:

PLEASE CIRCLE YOUR PAYMENT METHOD: SELF-PAY HEALTH INSURANCE WORK INJURY CAR ACCIDENT

IF YOU ARE ANYTHING OTHER THEN SELF-PAY HAVE YOU BROUGHT IN YOUR REFERRAL? IF SO, PLEASE GIVE IT TO YOUR THERAPIST OR THE RECEPTIONIST. WE WILL NEED A COPY OF YOUR HEALTH INSURANCE CARD AND DRIVERS LICENSE, PLEASE HAVE IT OUT AND READY FOR US. THANK YOU!

WORK INJURY OR CAR ACCIDENT CLAIM NUMBER: _____

INSURANCE COMPANY TO BE BILLED: _____

DATE OF INJURY:_____

REFERRING DOCTORS NAME: _____

ATTORNEY INFORMATION: _____

PATIENT NAME: _____ BIRTHDAY: ___/____/____

ADDRESS: _____ CITY:_____ STATE: ____ ZIP: _____

CELL PHONE NUMBER: _____ Email: _____
DO WE HAVE PERMISSION TO SEND YOU TEXT MESSAGE REMINDERS? YES NO

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT: _____ PHONE: _____ RELATION:_____

REFERRING PHYSICIAN: _____ CLINIC: _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR CLNIC? _____
PRIMARY AREA OF PAIN: _____ No Pain| 0 -1 – 2 – 3 – 4 - 5 - 6 – 7 - 8 – 9 – 10 | Max Pain

SECONDARY AREA OF PAIN: _____ No Pain| 0 -1 – 2 – 3 – 4 - 5 - 6 – 7 - 8 – 9 – 10 | Max Pain

HAVE YOU EXPERIENCED A MEDICAL MASSAGE BEFORE? YES NO

MY TREATMENT GOAL(S) WHILE HERE AT THIS CLINIC:
_____
_____
_____
_

INFORMED CONSENT TO TREAT

PLEASE LIST ANY HEALTH/MEDICAL CONCERNS YOU WOULD LIKE US TO BE AWARE OF:

_____
_____
_____
_____
_____

ALLERGIES THAT MAY PERTAIN TO OUR CLINIC THAT WE SHOULD BE AWARE OF: _____

THE NATURE OF TREATMENT: THE PRACTITIONER WILL USE HIS/HER HANDS AS WELL AS MASSAGE TOOLS, IF DEEMED NECESSARY BY PRACTITIONER, TO ACHIEVE RESULTS SUCH AS PAIN REDUCTION, DECREASE MUSCULAR SPASMS, INCREASED RANGE OF MOTION, DECREASED SWELLING, INCREASED BLOOD FLOW AND OXYGEN AND MUCH MORE, TO HELP THE PATIENT ACHIEVE OPTIMAL HEALH AND WELLNESS.

Massage Cupping:

-I UNDERSTAND THAT ALL TREAMENTS AT THIS FACILITY ARE THERAPUETIC IN NATURE. I AGREE TO COMMUNICATE TO THE THERAPIST ANY PHYSICAL DISCOMFORT OR DRAPPING ISSUES DURING MY SESSION.

-IF I AM UNSURE OF MASSAGE CUPPING OR OTHER TECHNIQUES USED AT THIS CLINIC I AM WILLING AND ABLE TO DISCUSS THESE TECHNIQUES WITH MY PROVIDER. I UNDERSTAND THE POTIENTAL EFFECTS AND AFTER-CARE RECOMMENDATIONS AS WELL.

I UNDERSTAND THAT IT IS MY CHOICE TO RECIEVE MASSAGE THERAPY. I AM AWARE OF THE BENEFITS AND RISKS OF MASSAGE AND FULLY GIVE MY CONSENT FOR MASSAGE. I UNDERSTAND THAT THERE IS NO IMPLIED OR STATED GUARANTEE OF SUCCESS OF EFFECTIVENESS OF INDIVIDUAL TECHNIQUES OR SERIES OF APPOINTMENTS. I ACKNOWLEDGE THAT MASSAGE THERAPY IS NOT A SUBSITUTE FOR MEDICAL CARE, MEDICAL EXAMINATIONS AND/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.

AUTHORIZATION TO BILL HEALTH INSURANCE/ASSIGNMENT OF BENEFITS:

I, _____ (PRINT NAME) DO HERBY GIVE FULL PERMISSION AND AUTHORIZE MERIDIAN MEDICAL MASSAGE, TO BILL THE INSURANCE COMPANY RESPONSIBLE FOR MY SERIVES RENDERED BY MERIDIAN MEDICAL MASSAGE. I ALSO AGREE TO HAVE ANY CHECKS OR PAYMENT MADE BY SAID INSURANCE COMPANY TO BE PAYABLE AND DELIVERED TO:

Meridian Medical Massage
16515 Meridian Ave E Suite 103b
Puyallup, WA 98375

I UNDERSTAND THAT I AM RESPONSIBLE FOR UNDERSTANDING INFORMATION ABOUT MY HEALTH INSURANCE POLICY AND PROVIDING SUCH INFORMATION TO MERIDIAN MEDICAL MASSAGE, FOR CORRECT BILLING. I AM ALSO RESPONSIBLE TO NOTIFY MERIDIAN MEDICAL MASSAGE IN THE CASE OF CHANGE OF MY HEALTH INSURANCE STATUS-INCLUSIVE BENEFITS AND ANY INFORMATION I RECIEVE RELATING TO CARE I HAVE OR WILL RECIEVE AT THIS CLINIC.

I UNDERSTAND THAT MERIDIAN MEDICAL MASSAGE BILLS MY INSURANCE AS A COURTESY AND ULTIMATELY, I AM RESPONSILBLE FOR ALL PAYMENT RELATING TO ANY AND ALL CHARGES AND BALANCES RELATING TO TREATMENT AND SERVICES THAT I HAVE RECIEVED AT MERIDIAN MEDICAL MASSAGE DURING MY CARE. I ALSO UNDERSTAND THAT MY INSURANCE POLICY MAY OFFER BENFITS FOR SERVICES PROVIDED, BUT TAHT SUCH BENEFITS DO NOT NECESSARILY QUARENTEE PAYMENT FOR THOSE SERVICES.

LATE CANCELATION & NO SHOW NOTICE:

YOUR APPOINTMENT TIME IS RESERVED FOR YOU IN ADVANCE. IF YOU ARE UNABLE TO MAKE IT TO YOUR SCHEDULED VISIT, PLEASE CALL 253-209-8535 AND NOTIFY US WITHIN 24-HOURS IN ADVANCE. THIS WILL ALLOW US TO FILL YOUR APPOINTMENT TIME WITH ANOTHER PAITENT WHO MAY NEED THE CARE. ***THERE WILL BE A $90.00 FEE FOR ALL MISSED APPOINTMENTS WITHOUT A 24-HOUR NOTICE***. THANK YOU FOR UNDERSTANDING.

Patient Signature: _____ Date: _____

Initial Injury Evaluation Form

PLEASE FILL THIS OUT IF YOU ARE BEING SEEN FOR A WORK INJURY CLAIM OR A CAR ACCIDENT

HAVE YOU RECIEVED MASSAGE THERAPY FOR THIS INJURY AT ANOTHER CLINIC ALREADY? YES NO

TIME OF INJURY:

1. When did the injury occur (date, time, and place)?

2. How did the injury happen? Briefly describe onset.

3. What symptoms did you experience immediately after injury?

4. Describe pain (ex. Sharp, stabbing, shooting, dull ache, throbbing, etc.)

5. What did you do immediately after the injury?

FOLLOWING INJURY:

1. Have you seen any other health care providers? If so, who?

2. Are you receiving any other treatment/therapy/medication for this injury? (ex. Chiro/PT/Acupuncture/Ibuprofen)

3. What symptoms have you been experiencing since the injury?

4. What makes symptoms worse?

5. What makes symptoms better?

6. Have you missed work due to this injury?

Meridian Medical Massage

Letter of Protection

I, the undersigned, authorize and direct my attorney to pay directly to Meridian Medical Massage all sums that may be due and owing for healthcare services for injuries from my personal injury claim arising on (date of injury): _____.

I understand that I am directly and fully responsible to the above clinic to pay the bills incurred on my behalf, whether or not my attorney recovers these medical bills from settlement or judgement.

Date: _____ Patient Printed Name: _____

Patient Signature: _____

As the attorney of record for the above patient; I hereby agree to observe all the terms of the above and agree to withhold such sums from the client's portion of any settlement, judgement, or verdict to pay the outstanding bill incurred by the above patient. I agree to call to confirm a final balance prior to remitting settlement funds to any other party.

Date: _____ Attorney Printed Name: _____

Attorney Signature: _____

Please date, sign and return this copy to Meridian Medical Massage at your earliest convenience to our fax at 253-862-6002. If this document is not signed and returned, our office may not be able to treat the above patient for accident-related injuries. Thank you for your partnership on this patient's journey back to health and wellness.

-Yours in health,

Jessica Lindbo, MMP, FMT, Owner

P: 253-209-8535 F: 253-862-6002