NEW CLIENT INTAKE FORM

Date_____

Patient Name_____ Birth Date _____

Home Address_____

Telephone #_____ Employer_____

Email Address_____

Injured in an automobile accident? Y/N Date of Accident_____

Insurance carrier_____ PIP or ID #_____

Name/Phone #of adjustor_____

Name/Phone of referring physician_____

Name/Phone/Relation of emergency contact_____

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 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.

Cancelation Policy
If cancellation is necessary, please give 24-hour notice. If you do not give notice you will be charged a $25 fee at your next appointment. The 2nd time it happens and anytime thereafter, you are charged for the full price of the massage missed. Emergency cancellations are determined at the practitioner's discretion.

Assignment of benefits
I am responsible for all charges for all service provided. In the unfortunate event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. If you, my massage therapist, have contracted with my insurance company at a discount rate for services, the amount remaining will be waived and I will not be asked to pay the balance. I authorize and direct payment of medical benefits to my massage therapist, for services billed.

Signature_____ Date_____