



How did you find us?

CHECK THE BOX THAT INDICATES HOW YOU HEARD ABOUT US

- Friend or Family Member: (Name) _____
 If "friend or family member," did they buy you a gift certificate? **YES NO**
- Medical Professional: (Name and Title) _____
- Advertising: Television Radio Outdoor ad Y. Pages Other: _____
- Internet: our website Facebook Instagram Twitter Yelp
 Google search Google Reviews Other: _____
- Community Event: (specify where you saw us) _____
- Other: (Please specify) _____
- I am a returning customer: (what kept you away?) _____

Contact Information

(If Client is under 18, this form should be completed by parent or guardian)

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zipcode: _____

Email Address: _____ Home Phone Number: _____

Cell Phone Number: _____ Cell Phone Provider: _____

Work Phone: _____ Occupation: _____

Preferred Method of contact (Please Circle One): Email or Text Message



Personal Health Information

(If Client is under 18, this form should be completed by parent or guardian)

PERSONAL DATA

First Name: _____ MII: _____ Last Name: _____ Birth Date: _____

Occupation: _____ Employer: _____ Today's Date: _____

Family Doctor: _____ Permission to Consult with Physician? Initial if Yes: _____

Emergency Contact: _____ Relationship: _____ Phone#: _____

MESSAGE HISTORY / TREATMENT INFORMATION

Have you ever received professional massage therapy?: _____ If Yes, how often?: _____

Date of last massage: _____ . What Results do you want to get from your massage session(s)?:

Prioritize the areas of your body that you would prefer to be massaged:

Please circle the areas of the body you give permission to be massaged:

- | | | | |
|-------------------|------------------------|--------------------|-------------------|
| Back | Hips | Upper Chest | Face |
| Upper Legs | Glutes/Buttocks | Neck | Feet/Hands |
| Lower Legs | Abdomen | Head | Arms |

In the Past 24 hours, have you had (A) a fever **YES NO** (B) any infection illness, cold, or flu (even if mild) **YES NO**

Are you currently seeing a medical practitioner?: _____ If Yes, please explain:

Are you currently involved in psychological counseling or regular support group meetings? _____
If Yes, please explain:

Please list stress reduction and exercise activities, including frequency:

Please list current medications, including aspirin, ibuprofen, etc:

PREVIOUS HISTORY

Please list past surgeries, including dates:

Please list past accidents, including dates

Client Health History

(If Client is <18 years old, this form must be completed by parent or guardian)

Please check all that apply and explain below:

MUSCULO-SKELETAL
Bone or Joint Disease
Tendonitis
Arthritis
Low Back/Hip/Leg Pain
Neck/Shoulder/Arm Pain
Headaches/Head Injuries
Spasms/Cramps
Jaw Pain/TMJ
Lupus
Broken Bones
Specify:
Sprains/Strains
Specify:
Other/Elaborate:

CIRCULATORY
Heart Condition
Varicose Veins
Blood Clots
High Blood Pressure
Low Blood Pressure
Lymph Edema
Breathing Difficulty
Sinus Problems
Allergies
Specify:
Other/Elaborate:

NERVOUS SYSTEM
Herpes/Shingles
Numbness/Tingling
Chronic Pain
Chronic Fatigue Syndrome
Sleep Disorders
Other/Elaborate:

REPRODUCTIVE
Women:
Pregnant (Trimester):
PMS
Men/Women:
Other/Elaborate:

INFECTIOUS DISEASE
Specify:

OTHER
Cancer
Diabetes
Eating Disorders
Depression
Drug/Alcohol Use
Nicotine/Caffeine Use
Other/Elaborate:

SKIN
Allergies
Specify:
Rashes
Warts
Other/Elaborate:

DIGESTIVE
Constipation
Gas/Bloating
Diverticulitis
Irritable Bowel Syndrome
Other/Elaborate:

Client Signature: _____ **Date:** _____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name: _____ **Relationship to Client:** _____

(if signee is not client)



Financial Policy

(If Client is under 18, this form should be completed by parent or guardian)

Dear Client/Patient:

Welcome to Creative Wellness, Inc. The intent of this document is to inform you of Creative Wellness's Financial Policy. It is our objective that all our patients receive the best possible care and service. Therefore, your complete understanding of our financial policy as it relates to your financial obligation is essential. Please read this document thoroughly. Upon presenting to the office, you will be asked to sign this form stating that you have read, understood and will comply with the information contained within this document.

Payment is expected at the time of service.

Insurance- **Please check with your insurance company prior to making an appointment for their requirements for your policy!** This includes coverage, co-pays, deductibles, referral requirements, etc. Upon your arrival, please have your insurance card with you so we may make a copy of your card.

Referrals:

1. If you are being referred to Creative Wellness by a physician because of an auto accident or workers compensation, please be sure we have all the necessary documents. This includes referrals, letter from the insurance company with your claim information, and a signed financial responsibility statement before your first appointment. If your paperwork is not complete prior to your first appointment you will be asked to pay in full.
2. If you are receiving acupuncture, a referral is required from your doctor.
3. Some insurance companies may require a doctor's referral for chiropractic treatment. At times this may change your co-pay costs. Please call the customer service number on your insurance card to find out how many visits your policy covers.
4. Some insurance companies may require a doctor's referral for massage treatments. At times this may change your co-pay costs. Please call the customer service number on your insurance card to find out if you have massage coverage.
5. Always be sure your referral is signed by your primary physician. For acupuncture a referral can be from any M.D. or D.O.

Payments:

1. If you are a member of a health plan that Creative Wellness participates with, and your service is covered, we will submit your claim to your insurance company. Your co-payment is expected at the time services are rendered. Patients will be billed in full for any services that their health plan deems as "not a benefit" or a "non-covered service".
2. If Creative Wellness does not participate with your insurance carrier, payment in full will be required of you at the time services are rendered.
3. We will provide you with an insurance receipt if you would like to submit to your insurance company for reimbursement.
4. Medicare patients are responsible for services in full. We do not participate with Medicare.
5. Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.
6. If a client is under the age of 18, this must be filled out by a parent or guardian.
7. Creative Wellness accepts cash, personal check, MasterCard, Visa, and ATM debit cards by the same carriers listed, as payments for services rendered.
8. A \$25 fee will be assessed for any check returned for insufficient funds. At that time only cash, charge or money order will be accepted for payment.
9. Creative Wellness reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collection fees, including attorney's fees, incurred by us in enforcing the terms hereof, whether or not formal legal proceedings are commenced.

As a courtesy to our practitioners, we ask that you give a 24-hour cancellation notice. Failure to keep your scheduled appointment or same day cancellations will result in a charge of \$25. After 3 late cancellations or missed appointments, the appointment will be charged in full. For parties of 3 or more, credit card numbers will be required for booking and any cancellation under 24-hours' notice will be charged in full.

Client Signature: _____ **Date:** _____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name: _____ **Relationship to Client:** _____

(if signee is not client)



Client/Patient Agreement

(If Client is under 18, this form must be completed by parent or guardian)

PLEASE INITIAL AND SIGN BELOW

It is my choice to receive therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasms or pain, or for increasing circulation or every flow. I agree to communicate with my practitioner any time I would like a modification to the procedure being used. **Initials:** _____

I understand that practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service. **Initials:** _____

I have stated all medical conditions of which I am aware, and will update the massage practitioner of any changes to my health status. **Initials:** _____

I agree that I will inform my provider of any special needs or treatment requests at the time that treatment is provided. I agree other employees of Creative Wellness, such as reception staff, do not have the medical expertise to ensure that my requests can or will be honored, and that the best outcomes will result from an open dialogue with my provider at that time of treatment. **Initials:** _____

I was able to review the Creative Wellness, Inc. Notice of Privacy Practices at Creative Wellness. The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. I know that I can ask for a copy of the Notice of Privacy Practices to take with me. I was able to view the Notice of Privacy Practices on the first day I received health care services after April 14, 2003. If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonably practicable after the emergency treatment situation.

Initials: _____

I agree to be financially responsible for all charges incurred at Creative Wellness including, if applicable, any deductible, co-payment, and any services rejected by my insurance company. I understand that Creative Wellness is not responsible for any incorrect information provided by my insurance company regarding coverage and care. **Initials:** _____

As a courtesy to Creative Wellness therapists, I understand that I am expected to give 24-hours' notice of a cancellation. If I give less than 24-hours' notice, I understand that there will be a \$25 cancellation fee, and my appointment will be charged in-full after 3 late cancellations. For parties of 3 or more, I will be required to give credit card numbers prior to booking and any cancellations under 24-hours notice will be charged in-full. **Initials:** _____

Client Signature: _____ **Date:** _____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name: _____ **Relationship to Client:** _____

(if signee is not client)