MASSAGE THERAPY REGISTRATION AND HISTORY

1 CLIENT INFORMATION

Date_____

Client_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

_____

2 INSURANCE

Who is responsible for this account?_____

Relationship to Client_____

Insurance Co._____

Group #_____

Is client covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Client_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

3 PHONE NUMBERS

Home_____ Work_____ Ext____

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home Phone_____ Work Phone_____

4 ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No Date_____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)_____

5 CLIENT CONDITION

When did your symptoms appear?_____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None ☐ Other_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?_____ Is it constant or does it come and go?_____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

Name and address of doctor(s) or other healthcare practitioner(s) who have treated you for your condition:

Name_____ Name_____

Address_____ Address_____

Phone_____ Phone_____

– TO REVERSE SIDE –

6 MASSAGE HISTORY

Have you ever received a professional massage? ☐ Yes ☐ No

Why did you come for our service? ☐ Relaxation ☐ Pain ☐ Therapy ☐ Other_____

What results would you like to achieve?_____

_____

Prioritize the areas of your body that you wish to be massaged. Please note any areas of your body that you **prefer not to be massaged.** _____

7 HEALTH HISTORY

Please check ☑ conditions or symptoms you currently have or have had in the past:

- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Breathing Difficulty
- ☐ Bursitis
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaw Pain/TMJ
- ☐ Lymphedema
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Pinched Nerve
- ☐ Pneumonia
- ☐ Polio
- ☐ Prosthesis
- ☐ Psychiatric Care
- ☐ Rheumatoid Arthritis
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tendonitis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors, Growths
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Whiplash
- ☐ Other_____

MEDICATIONS

Medication _____ Taking For _____

_____ _____

_____ _____

ALLERGIES

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

EXERCISE

☐ None ☐ Daily ☐ Moderate ☐ Heavy

WORK ACTIVITY

☐ Sitting ☐ Light Labor ☐ Standing ☐ Heavy Labor

LIFESTYLE

☐ Smoking Packs/Day_____ ☐ Coffee/Caffeine Cups/Day_____

☐ Alcohol Drinks/Week_____ ☐ High Stress Level Reason_____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Please list any medical conditions, surgeries, accidents, and bone, joint or muscle diseases or injuries not specified above.

_____ _____ _____ _____

Date Date

8 AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status.

I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me.

I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

Date_____ Signature_____

BENEFITS OF MASSAGE

MASSAGE CAN BENEFIT THOSE WHO SUFFER FROM STRESS IN THEIR LIVES, PEOPLE WITH BACK OR NECK PAIN, INJURIES OR THOSE WHO EXERCISE FREQUENTLY. IN THE CASE OF STRESS RELIEF, OUR MENTAL TENSIONS QUICKLY BECOME MUSCLE TENSIONS. MASSAGE CAN COUNTERACT THAT TENSION AND RELAX YOU. HOW? THROUGH AN INDIRECT FEEDBACK SYSTEM. MUSCLE TENSION IS CONTROLLED BY THE BRAIN, CONSISTENTLY REFLECTING YOUR PSYCHOLOGICAL STATE. THE SOOTHING PHYSICAL SENSATIONS PRODUCED BY MASSAGE FEED BACK TO THE BRAIN AND REDUCE ANXIETY. THE BRAIN IN TURN TELLS ALL THE MUSCLES TO UNWIND. THAT'S WHY MASSAGE IN ONE AREA CAN PRODUCE A BODY-WIDE FEELING OF RELAXATION.

BACK AND NECK PAIN ARE THE MOST COMMON SPECIFIC COMPLAINTS SEEN BY MASSAGE THERAPISTS. SIMPLE MUSCLE TENSION IS OFTEN THE CAUSE. BUT MASSAGE MAY HELP WHEN THE CAUSE IS NOT SO SIMPLE. MASSAGE HAS BEEN USED TO RELIEVE PAIN AND PROMOTE HEALING BY INCREASING CIRCULATION TO WHIPLASH-INJURED NECK MUSCLES. MASSAGE OF THE SCALP IS USED FOR CHRONIC DISCOMFORT FROM HEADACHES, AND JAW MASSAGE IS USED TO EASE C JOINT. IN ADDITION TO MASSAGING THE AFFECTED AREA, A BACK AND NECK MASSAGE CAN SOMETIMES HELP RELIEVE POSTURE RELATED MUSCLE STRAIN.

A SMALL STUDY FROM NORWAY SUGGESTS THAT MASSAGE NOT ONLY RELAXES MUSCLES, BUT ALSO PUTS THE BODY'S OWN ANESTHETICS TO WORK ON PAIN. RESEARCHERS MEASURED THE BLOOD LEVELS OF BETA-ENDORPHINS (NATURALLY OCCURRING PAIN KILLERS) IN 12 VOLUNTEERS AFTER EACH UNDERWENT A 30 MINUTE MASSAGE. THE RESULT WAS A 16% AVERAGE INCREASE IN THE RELEASE OF ENDORPHINS IN THE BODY.

MASSAGE CAN ALSO HELP REDUCE OTHER SYMPTOMS OF INJURY SUCH AS EDEMA AND SWELLING. MASSAGE CAN STIMULATE THE CIRCULATION OF BOTH BLOOD AND LYMPHATIC FLUID, WHICH TEND TO POOL AROUND THE SITE OF AN INJURY. THE LYMPHATIC SYSTEM IS AN ADDITIONAL DRAINAGE ROUTE THAT REMOVES WASTES FROM THE TISSUES. THEORETICALLY, REDUCING SWELLING IN THIS MANNER ENCOURAGES HEALING BY ALLOWING OXYGEN AND NUTRIENT RICH BLOOD TO FLOW BACK TO THE TISSUES.

IN ADDITION TO THE BENEFITS MENTIONED ABOVE, MASSAGE CAN HELP REMOVE LACTIC ACID FROM FATIGUED MUSCLES. LACTIC ACID BUILD UP CAN OCCUR DURING EXERCISE, CAUSING MUSCLE CRAMPS. MASSAGE REALLY HELPS REDUCE PAIN AND FATIGUE. IN ADDITION TO ALL OF THESE VALUABLE BENEFITS, MASSAGE REPLACES STRESS AND TENSION WITH A PEACEFUL AND RELAXED STATE OF MIND.

GIVE THE GIFT OF RELAXATION
MASSAGE GIFT CERTIFICATES
AVAILABLE

RED ROCK CHIROPRACTIC
TREATMENT AUTHORIZATION

Please Answer The Following Questions

Have you or are you currently suffering from any injuries, illnesses or other conditions that could possibly effect your treatment?

NO_____ YES_____ If yes, please describe:_____

_____

Are you currently taking any medication?

NO_____ YES_____ If yes, please describe:_____

Are you pregnant?

NO_____ YES_____ If yes, please describe:_____

I understand that the massage therapy given here at Red Rock Chiropractic is for the purpose of the relief from muscular tension, stress reduction or relaxation. I understand that the therapist does not treat or diagnose illness or disease. I further understand that it is recommended that I consult a physician before beginning the above treatments. Red Rock Chiropractic reserves the right to deny treatment due to medical reasons. I understand that Red Rock Chiropractic is not responsible for any lost or stolen items. I also understand that I am responsible for and assume the risk for any injury that I may sustain while on the premises and do hereby for myself my heirs, administrators assigns release, and forever discharge Red Rock Chiropractic its owners, operators, members agents, officers, and employees from any personal injury I may sustain while on the premises of Red Rock Chiropractic.

Signature:_____ Date:_____

Witness: _____ Date:_____

DR. MARGARET R. COLUCCI

Red Rock Chiropractic & Wellness Center
2085 Village Center Circle #110
Las Vegas NV 89134

(702)880-5335

INFORMED CONSENT TO TREAT

The information I have given this office and my treating doctor is complete and true to the best of my knowledge. I understand the risks associated this form of treatment and I will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary. They have not stated or implied any guaranteed of cure. "24 Hour notice of cancellation is required to avoid a broken appointment charge of $40.00. I am responsible for payment of this charge.

Patient's Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

INFORMED CONSENT TO TREAT A MINOR CHILD

The information I have given this office and my treating doctor pertaining to _ ____ is complete and true to the best of my knowledge. I understand the risks associated with this form of treatment and will take the responsibility to ask the doctor to clarify any of my considerations or areas of treatment that I do not completely understand. I authorize the doctors and staff to administer such procedures and treatment as they deem necessary to my **child/ward** in my legal custody. They have not stated or implied any guaranteed of cure.

Parent/Guardian Signature:_____ **Date:**_____

Relationship to Minor:_____

Witness:_____ **Date:**_____

RED ROCK
CHIROPRACTIC
& WELLNESS
CENTER

Dr. Margaret R. Colucci
& Associates

Office 702 880.5335
Fax 702 880.5336

www.redrock
chiropractic.com

2085 Village Center Circle
Suite 110
Las Vegas, Nevada 89134

Financial Policy

Thank you for choosing us as your Chiropractic provider. Our main concern is that you receive the proper chiropractic care as needed to maintain optimum spinal health. If you have any questions , Please do not hesitate to ask our staff and/ or doctor.

Our practice firmly believes that a good doctor/ patient relationship is based upon understanding and open communication. The following information is designed to provide you with detailed information about our policies and financial policies to allow a better understanding of your financial liabilities for our professional services.

*Payments for services are due at the time services are rendered. We accept cash, checks, and for your convenience, MasterCard and Visa.

Please read the following and initial each line:

_____ 1.All co- pays and deductible are due at the time of your visit. Payment for services for cash visits are due " In Full" at the time of your visit. We accept cash Checks and Master Card.

_____ 2.We will submit an insurance claim on your behalf as a courtesy, if we have a provider contract with your Insurance Company. However, it is your responsibility to follow up with your insurance company in the event that your claim is unpaid. If any of your personal information changes, it is your responsibility to notify us and provide a copy of the new insurance card to us immediately. (WE DO NOT BILL SECONDARY INSURANCE).

_____ 3.Your insurance policy is a contract between you, your employer and your insurance company. We are Not a party to that contract. Our relationship is with you and not your insurance company. You are ultimately responsible for any services provided, regardless of your insurance coverage.

_____ 4.Your insurance company does not cover all services that are provided .It is your responsibility to know the limitations and benefits. Fees for no-covered services are due at the time they are rendered.

_____5. If your insurance company requires a referral from your Primary Care Physicians (PCP), it is your responsibility to have this with you at the time of your visits or your will be responsible for payment of the service.

_____ 6 If your insurance does not pay within 60days from your visit, we reserve the right to begin billing you directly and that you contact your insurance carrier. Accounts will be considered delinquent after 90 days . Deliquent accounts will be placed with a private collection agency. Any and all accounts placed with the collection agency will be subject to all reasonable collection, interest and filing fees and court cost.

_____ 7 Should you receive payment from your insurance company or lien for services provided by Red Rock Chiropractic & Wellness Center, You have 10 days to forward the said monies to our office. Should you fail to carry out this, we will report it to the Internal Revenue Services (IRS) as an income and not a reimbursement and we will place the account with the collection agency.

_____ 8. Returned Checks are subject to a $25.00 returned check fee. of any services you receive. .

RED ROCK
CHIROPRACTIC
& WELLNESS
CENTER

Dr. Margaret R. Colucci
& Associates

Office 702 880.5335
Fax 702 880.5336

www.redrock
chiropractic.com

2085 Village Center Circle
Suite 110
Las Vegas, Nevada 89134

_____ 9 A charge of $40.00 will be assessed for any missed and cancelled appointments without 24-hour notice. This is to the patient's personal responsibility: we can not bill this to the insurance
You will be responsible to make up any missed appointment with in the week in order not to be charged the missed appointment fee.

_____ 10. Insurance companies do not cover supplement' and or supplies such as: neck and back support pillows. They are the patient's responsibility. Please consult with our front office regarding products and prices.

_____ 11.For any unpaid past due balances over 30 days old, a late fee of 1.5% per month will be assessed. Unpaid balances over 30 days are subject to further collection actions by an outside agency , unless payment arrangements have been made in writing.

_____ 12. All Returns on supplies and supplements are subject to a restocking fee and must be returned within 10 days from the date of purchased. All special orders are subject to a shipping fee.. No cash refunds will be issued only a credit will be applied to your account. After 10 days all sales are final.

_____ 12.All returns on Spinal Pelvic Stablizers (Orthotics) are subject to a non- refundable $50.00 molding fee. I understand I am responsible for all shipping fees to return the product. You have 30 days from the date of receipt to receive a refund. After 30 days all sales are final.

_____ 14. I understand I am responsible to follow up with my insurance company as to when I reach my maximum benefit. (We are not always notified by all insurance carriers in a timely manner).

_____. 15. I understand I am responsible to follow up with my insurance company as to when I reach my maximum benefit. (We are not always notified by all insurance carries in a timely manner)

_____ 16). Effective as of August 17, 2015 all credit cards and debit cards will have a service charge of $1.00 per each transaction as a service fee. We accept Visa, Master card and Discover . We do not accept American Express .

We do understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

_____ _____
Signature of Patient/ Guarantor **Date**

_____ _____
Witness **Date**