Best BODY MOVES
Move Smarter.™ Live Better.

3220 Uddenberg Ln Ste 3 Gig Harbor WA 98335
Phone **206-713-7169**
Fax 253-358-3057

INSURANCE REGISTRATION

GENERAL

Last Name:				Marital Status:	
First:		Middle:		Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐	
Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):		Birth Date:	Age:	Gender: ☐ M ☐ F ☐ Other
Street address:		Cell Phone: ( )		Home Phone: ( )	
City:	State:	ZIP:	Email:		

Should our office need to contact you for any reason, may we leave you voicemail or e-mail correspondence? ☐ Yes ☐ No

Occupation:	Employer:	
Employer Address:	Work Phone: ( )	☐ Full time ☐ Part time
Spouse Name:	Spouse Employer:	Spouse Birth Date:
Primary Care Provider:	Provider Phone:	

PRIMARY INSURANCE

Is Client covered by insurance?	☐ No	☐ Yes	PPO ☐	Medicare ☐	FECA Black Lung ☐
Is Pain Due to a **Work Injury**? ☐ No ☐ Yes Date:			Claim ID:		
Primary insurance:					
Insurance address:			Phone: ( )		
Subscriber's Name:	Birth Date:	ID Number:	Group Number:	Office Co-Pay: $	
Client's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

AUTO INSURANCE

Is Pain Due to a **Motor Vehicle Accident**? ☐ No ☐ Yes Date:			Claim ID:	
Auto Insurance:	Subscriber's Name:	Policy Number:	Group Number:	
Insurance Address:		Phone: ( )		
Client's relationship to subscriber:	☐ Self ☐ Spouse ☐ Child ☐ Other		Claim Rep Name:	

EMERGENCY CONTACT

Name of local individual not living at same address:	Relationship to Client:	Home Phone: ( )	Work Phone: ( )

The above information is true to the best of my knowledge.

X

Client/Guardian Signature *Date:*

Please Draw X's or Circles to Show Problem Areas.

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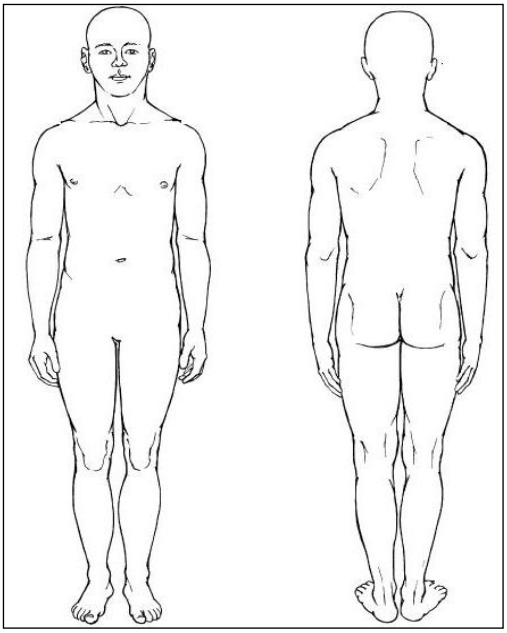

Date Problem Began: _____

☐ Work Injury ☐ Automobile Injury ☐ N/A

Describe Current Problem: _____

_____

_____

_____

Indicate Today's Pain Level For Your Primary Concern:

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Pain **Unbearable Pain**

How often is your primary symptom present? ☐ 0 – 25% ☐ 26 – 50% ☐ 51 – 75% ☐ 76 – 100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe)_____

_____

Have you had imaging: X-rays ☐ Yes ☐ No **MRI** ☐ Yes ☐ No **CT Scan** ☐ Yes ☐ No

If yes, what did they indicate? _____

_____

Please check all conditions listed below that currently apply:

Musculo-Skeletal
o Artificial Joint: Hip / Knee / Shldr
o Arthritis
o Headache: front / back / side
o Jaw pain / TMJ Disorder
o Joints: fusion / pain / swelling
o Osteoporosis / Osteopenia
o Strain / Sprain
o Tendinitis

Circulatory & Respiratory
o Asthma / Sleep Apnea / Bronchitis
o Blood clot
o Heart condition
o High blood pressure
o Stroke
o Varicose veins

Skin
o Rash / Allergy
o Warts

Digestive
o Acid reflux or Gastric ulcer
o Diverticulitis
o Gastric Band/Sleeve/Bypass
o Irritable Bowel Syndrome

Nervous System
o Concussion / Traumatic Brain Injury
o Fibromyalgia
o Herpes / Shingles
o Multiple Sclerosis / Parkinson's
o Other:
_____

Other
o Diabetes
o Cancer
o Implanted Medical Device:
_____
_____
o Accidents (0→5 years ago):
_____
_____
_____
o Surgeries (0→1 year ago):
_____
_____
_____
o What else would you like us to know?
_____

PAYMENT AGREEMENT

Medical Health Insurance:

I am the Client or Guardian, and hereby direct and instruct my Medical Health Insurance to make payment directly to **Best Body Moves**, **LLC** for medical claims submitted by them on my behalf for medically necessary massage treatment.

I understand my medical insurance and/or auto insurance contract is an agreement between the insurance company and myself. I agree and acknowledge that I am responsible to **Best Body Moves, LLC** for payment of any balance due, including but not limited to **annual deductible, office co-pay, co-insurance and unpaid service fees** due to them according to my policy coverage, in the event they are unable to collect from my insurance carrier or attorney, and in the case where **Best Body Moves, LLC** is holding an attorney lien on my behalf.

I understand that payment for services not received within 90 days of last service will be turned over to an outside collection agency representing **Best Body Moves, LLC**. If this occurs, in addition to my balance, I agree to also be held responsible for payment of billing office fees, attorney fees, collection agency fees, and any court costs incurred to collect my account on behalf of **Best Body Moves, LLC**.

Client Initials X_____

Client Retaining an Attorney:

If I have or expect to retain an attorney, it is understood that should it be agreed ***in advance*** that **Best Body Moves**, **LLC** carries my account until settlement, then **interest shall be charged at a monthly basis of 1% per month at an annual rate of 12%**. I agree that I am responsible for making sure interest charges are paid in full at time of my settlement. I understand that payment for services not received within 90 days of settlement will be turned over to a collection agency representing **Best Body Moves, LLC**. If this occurs, in addition to my balance, I agree to also be held responsible for payment of billing office fees, attorney fees, collection agency fees, and any court costs incurred to collect my account on behalf of **Best Body Moves, LLC**.

Client Initials X_____

APPOINTMENT POLICY AGREEMENT

- **I acknowledge that 12 hours' notice is required for rescheduling and cancelation. Less notice may result in a service charge and/or denial of additional therapy.**

Client Initials X_____

Client Full Name (print): _____

Client Signature: X_____ Date: _____
(Must be18 years or older.)

Guardian Signature: X_____ Date: _____

PRIVACY POLICY

I understand that as part of my health care, **Best Body Moves**, **LLC**, originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a 3rd-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

Any other uses and disclosures will be made ONLY with my authorization. I understand that I may revoke my authorization for other uses in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that I have the following rights and privileges:

- The right to inspect and obtain a copy of my health care information and
- The right to amend my health care information and
- The right to request a current copy of this Notice of Privacy Practices in email or US mail and
- The right to request restrictions as to how my health care information may be used or disclosed to carry out treatment, payment, or health care operations by presenting a written request to a member of the Best Body Moves, LLC staff.

I further understand that **Best Body Moves, LLC** reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations.

Treatment of Minors:
Any person under the age of 18 years of age, unless legally emancipated by the courts, is deemed a minor in the state of Washington. Parents and Guardians must also complete the separate *Consent to Work with Minor* form available at the clinic.

I fully understand and **accept** the terms of this consent.

X_____ _____

Client or Guardian Signature – Must be18 years or older. Date