

# Myofascial Treatment Center of Modesto

Patient Information Sheet

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Mailing Address City State Zip Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Home Phone Number Date of Birth Age Female Male

\_\_\_\_\_  
Email address Driver's License

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number Cell Phone Number

\_\_\_ Married \_\_\_ Single \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed

Is your condition the result of a work injury? Is your condition the result of an auto accident?  
Yes \_\_\_ No \_\_\_ Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
Date of injury Time of injury Date Last Worked Place of Injury

\_\_\_\_\_  
Patients Employer Employer Phone Number

## PARENT/SPOUSE INFORMATION

*If you are a parent/spouse of the patient, complete this part of the form. If not, skip to Emergency Contact Information*

\_\_\_\_\_  
Relationship to Patient Parent/Spouse Last Name Parent/Spouse First Name

\_\_\_\_\_  
Mailing Address City State Zip Code

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Social Security Number Phone Number

## EMERGENCY CONTACT INFORMATION

\_\_\_\_\_  
Relative whom we can contact in event of emergency. Relationship

\_\_\_\_\_  
Home Phone Number Work Phone Number

## LEGAL INFORMATION

*If you are represented by an attorney for this injury, please complete this part of the form. If not, skip to insurance.*

\_\_\_\_\_  
Attorney Name

\_\_\_\_\_  
Mailing Address City State Zip Code

\_\_\_\_\_  
Work Phone Number

**INSURANCE INFORMATION**

Do you have insurance?

Yes \_\_\_ No \_\_\_ Private Pay \_\_\_

If so, what type of insurance do you have?

\_\_\_ PPO \_\_\_ HMO \_\_\_ Workman’s Comp

\_\_\_\_\_  
Primary Insurance Name Subscriber Name

\_\_\_\_\_  
Insurance City State Zip Code

\_\_\_\_\_  
Adjuster Insurance Group Number

\_\_\_\_\_  
Identification Number Effective Date Percent of Coverage

*If you do not have secondary insurance, skip to Financial Agreement.*

\_\_\_\_\_  
Secondary Insurance Name Subscriber Name

\_\_\_\_\_  
Insurance City State Zip Code

\_\_\_\_\_  
Adjuster Insurance Group Number

\_\_\_\_\_  
Identification Number Effective Date Percent of Coverage

**Financial Agreement, Assignment of Benefits and Authorization for Treatment**

I authorize treatment of the person named above and agree, irrevocably, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of insurance benefits directly to the provider named above, and any assisting physicians for services rendered. As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney’s fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original.)

\_\_\_\_\_  
Signature Date

**Release of Information**

The provider may disclose all or part of the patient’s record to any person or corporation which is or may be liable under a contract to the provider or to the patient, family member, or the employer of the patient or the family member for all or part of the providers charge, including but not limited to, medical service companies, workman’s compensation carriers, welfare funds, or the patient’s employer. I further authorize my employer to release employment information to the provider or the provider’s agents.

\_\_\_\_\_  
Signature Date

Is this the first time you have had this pain/complaint?

Yes  No

Have you been hospitalized or had surgery for this same or similar pain/complaint before?

Yes  No

Did you see a health professional within seven days of the onset of your pain/complaint?

Yes  No

Do you use tobacco?

Yes  No

Do you chew?

Yes  No

Do you smoke?

Yes  No

How physically demanding is your job? Include housework if you are not employed outside the home.

0  4  8  
 1  5  9  
 2  6  10  
 3  7

How much have you been able to control (i.e. reduce/help) pain/complaint on your own during the past week? (0 for being able to reduce your pain, 10 for not being able to reduce it at all)

0  4  8  
 1  5  9  
 2  6  10  
 3  7

During the last week how often have you taken medication for your pain/complaint?

3+ times a day.  
 Once or twice a day.  
 Once every couple of days.  
 Once a week.  
 Not at all.

How many episodes of your pain/complaint have required treatment?

0  1 - 3  4+

Please indicate your usual level of pain during the past week [0 for no pain, 10 for worst possible pain].

0  4  8  
 1  5  9  
 2  6  10  
 3  7

How long ago did your current episode begin?

Less than two weeks ago.  
 Two weeks to less than eight weeks ago.  
 Eight weeks to less than three months ago.  
 Three months to less than six months ago.  
 Six months to twelve months ago.  
 More than twelve months ago.

If you smoke, how often?

Less than one pack a day.  
 More than one pack a day.

Please indicate how depressed you have been feeling during the past week (0 for not depressed at all, 10 for extremely depressed).

0  4  8  
 1  5  9  
 2  6  10  
 3  7

How anxious (e.g. tense, uptight, irritable, fearful, difficulty in concentrating/relaxing) have you been feeling during the past week? (0 for not at all, 10 for extremely anxious)

0  4  8  
 1  5  9  
 2  6  10  
 3  7

If you had to spend the rest of your life with your condition as it is right now, how would you feel about it?

Delighted  
 Pleased  
 Mostly satisfied  
 Mixed  
 Mostly dissatisfied  
 Unhappy  
 Terrible

Have you ever received hand-on therapies before?  
(i.e. Myofascial Release or Soft Tissue Therapy)

Yes  No

Do you have diabetes?

Yes  No

Are you pregnant?

Yes  No

Are you wearing contact lenses?

Yes  No

Do you suffer from joint swelling?

Yes  No

Do you have osteoporosis?

Yes  No

Do you have any cardiac or circulatory problems

Yes  No

Do you have high blood pressure?

Yes  No

If, so are you taking any medication for this?

Yes  No

What is the name of this medication?

Do you have any contagious diseases?

Yes  No

Please explain:

Have you had any broken bones?

Yes  No

Please explain:

Do you have any other medical conditions I should be aware of?

Yes  No

Please explain:

Do you frequently suffer from stress?

Yes  No

Do you have frequent headaches?

Yes  No

Do you suffer from arthritis?

Yes  No

Do you suffer from epilepsy or seizures?

Yes  No

Do you have varicose veins?

Yes  No

Do you bruise easily?

Yes  No

Does your pain/condition limit your ability to sleep?

Yes  No

Have you ever had surgery?

Yes  No

Please explain:

Do you have any allergies?

Yes  No

What are they?

Does your pain/condition increase with activity?

Yes  No

Please explain:

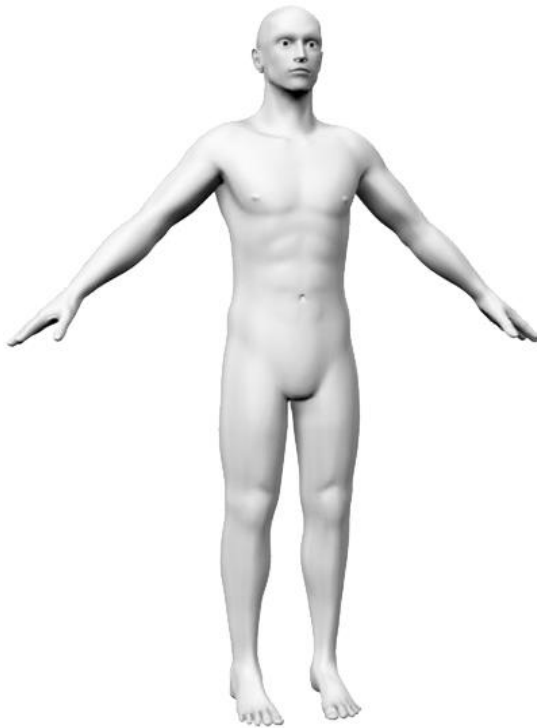
Does your pain/condition cause difficulty with intercourse?

Yes  No

Please explain:

Show the location of your pain/complaint by drawing the appropriate symbols on the figures below.

<b>Sharp and Stabbing</b> + + + + + +	<b>Dull and Achy</b> V V V V V	<b>Numbness</b> / / / / /	<b>Pins and Needles</b> 0 0 0 0 0
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Please take a moment to carefully read the following information and sign where indicated. If you have a particular medical condition or specific symptom, Myofascial Release/Soft Tissue Therapy may be contraindicated. A referral from your primary care provider may be required prior to treatment.

**Agreement**

I understand that the Myofascial Release/Soft Tissue Therapy I receive is provided for the purpose of relief of muscular tension and relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that Myofascial Release/Soft Tissue Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that Myofascial Release/Soft Tissue Therapy practitioners are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe or treat any physical or mental illness, and that nothing said in the course of treatment should be construed as such. Because Myofascial Release/Soft Tissue Therapy should not be performed under certain medical conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I forget to do so.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Therapist Signature \_\_\_\_\_ Date \_\_\_\_\_

**Consent for Treatment of a Minor**

By my signature below, I hereby authorize \_\_\_\_\_ to administer treatment techniques to my child or dependent as they deem necessary.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Images for Medical Records**

With my signature, I (print name) \_\_\_\_\_ give my consent to be photographed for medical record purposes. These photograph images will be used to accurately record progress and be used by the therapist, doctor and insurance representative. Images will be taken as needed to show progress in the chart. My signature does not give permission for publication or circulation other than in above mentioned circumstances.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Date placed in chart \_\_\_\_\_



## Soft Tissue and Myofascial Treatment, Inc. Myofascial Treatment Centers

<http://mfr4painrelief.com>

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(209) 492.0355 Fax 521.0955

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### ***Cancellation/No Show Policy***

It is the policy of the Myofascial Treatment Center that scheduled appointments that are canceled with a 24 hour notice or more, there will be no charge. Appointments that are canceled with less than 24 hours will be charged at half the cost of the scheduled visit.

No Show Appointments: if you have a scheduled appointment and you no show the appointment (do not come in for the appointment) and do not call **you will be billed for the full cost of that visit.** This includes workers compensation patients. Although we cannot bill workers compensation for your no show appointment we call and will bill you.

### **Payment of Services Fee's affective June 1, 2014**

*Payment is to be made at time of visit or arranged in advance. Each office visit/treatment is \$110.00. A discount is given for payment at time of visit. Billed amount will be \$110.00 if done after visit and sent as a statement to your home.*

### **Insurance Co-payments Policy**

Insurance co-payments are due at the time of your visit. In some cases we do not know what your co-pay will be until we receive reimbursement back from your insurance company. We will charge a standard co-pay of \$35.00 per visit until we determine your co-pay and coverage. At that time we will refund any overpayments back to you or present you with the amount you may owe the Myofascial Treatment Center due to a short fall by your insurance. **Because of administrative costs and overhead all insurance reimbursements must meet our cost per visit.** If you need clarification on this policy please ask us and we will be happy to explain in greater detail.

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Signed

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Date

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