Myofascial Treatment Center

Patient Information Sheet

_____ _____ _____
Last Name First Name Middle Initial

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ ___/___/_____ _____ _____ _____
Cell Phone Number Date of Birth Age Female Male

_____
Email address

____/_____/_____ _____
Social Security Number- **If requested** Home Phone Number

___ Married ___ Single ___ Separated ___ Divorced ___ Widowed

Is your condition the result of a work injury?
Yes ___No ___

Is your condition the result of an auto accident?
Yes ___No ___

_____ _____ _____ _____
Date of injury Time of injury Date Last Worked Location of Injury

_____ _____
Patient's Employer Employer Phone Number

PARENT / SPOUSE / EMERGENCY CONTACT 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 Last Name First Name

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ _____
Home /Cell 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

Are you using insurance for your visits?
Yes ___ No ___ Private Pay ___

If so, what type of insurance are you using?
____ PPO ____ HMO ____ Workman's Comp

To ensure that we have all necessary information to bill insurance for patient visits, please provide your insurance card to the person at the front desk so that they can make a copy of it. -Thank you

REFERAL INFORMATION

Relationship to Patient

_____ Physician _____ Family Member _____ Friend _____
Name of Person Who Referred Patient

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

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 ___ NA

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 we should be aware of?
___ Yes ___ No

- Please explain:

Do you use tobacco? Do you chew?
___ Yes ___ No ___ Yes ___ No
Do you smoke? Do you vape?
___ Yes ___ No ___ Yes ___ No

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

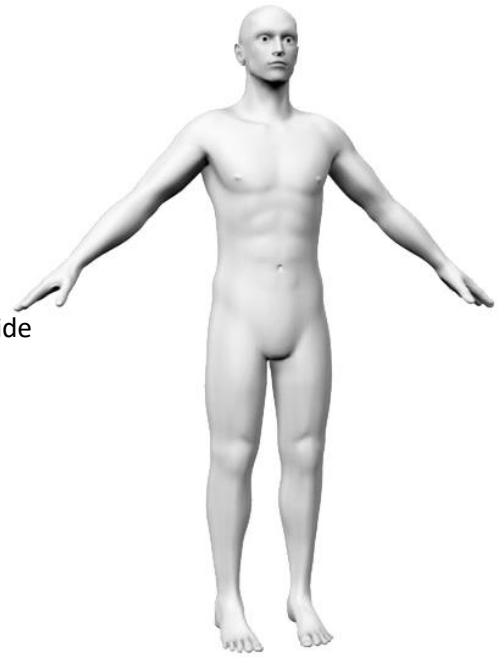
- Please explain:

Does your pain/condition cause difficulty with intercourse?
___ Yes ___ No

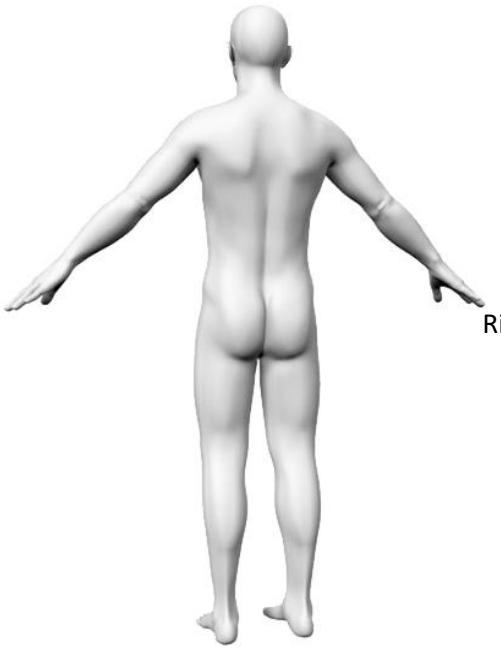
- Please explain:

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

Sharp and Stabbing	Dull and Achy	Numbness	Pins and Needles
+ + + + + +	V V V V V	/ / / / /	0 0 0 0 0



Right Side



Left Side Right Side

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 **The Myofascial Treatment Center** 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://MFReducation.com

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(209) 492-0355

920 Pacific Ave
Crescent City, California 95531
(707) 951-3754

FAX: (209) 521-0955

Cancellation / No Show Policy

It is the policy of the Myofascial Treatment Center that scheduled appointments that are canceled with 24 hours' 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 can and will bill you.

Payment of Services Fee's affective January 1, 2019

Payment is to be made at time of visit or arranged in advance. Each office visit/treatment is $135.00. A discount is given for payment at time of visit. Billed amount will be $135.00 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.

_____ _____

Signed Date