

# Revive Therapeutics

## Confidential Client Information Form

Name: \_\_\_\_\_ M \_\_\_ F \_\_\_ Birthday \_\_\_/\_\_\_/\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ How did you hear of us? \_\_\_\_\_  
 Date of Accident/Injury: \_\_\_\_\_ When did you first start feeling symptoms? \_\_\_\_\_  
 What have you done/are doing for your condition? \_\_\_\_\_  
 How frequently do you receive body work? \_\_\_\_\_

### Insurance Information

Insurance Company \_\_\_\_\_  
 Subscriber \_\_\_\_\_  
 ID # \_\_\_\_\_ Group # \_\_\_\_\_  
 Copay Amount \_\_\_\_\_  
 Referring Provider / Phone # \_\_\_\_\_

#### DESCRIBE YOUR PAIN LEVEL

Minimal \_\_\_\_\_  
 Mild \_\_\_\_\_  
 Moderate \_\_\_\_\_  
 Intense \_\_\_\_\_  
 Severe \_\_\_\_\_

#### TYPE OF PAIN

Pins and Needles \_\_\_\_\_  
 Numbness \_\_\_\_\_  
 Burning \_\_\_\_\_  
 Dull/Deep Ache \_\_\_\_\_  
 Stiffness/Tightness \_\_\_\_\_  
 Sharp/Stabbing \_\_\_\_\_

#### FREQUENCY

Constant 24/7 \_\_\_\_\_  
 Daily \_\_\_\_\_  
 Weekly \_\_\_\_\_  
 Intermittent \_\_\_\_\_  
 Occasional \_\_\_\_\_  
 Only with specific movement \_\_\_\_\_

**PLEASE MARK ON THE ILLUSTRATIONS BELOW ANY AREAS YOU ARE EXPERIENCING PAIN, DISCOMFORT, TIGHTNESS, NUMBNESS, TINGLING, ETC.**

What makes your condition worse? \_\_\_\_\_  
 \_\_\_\_\_

What makes your condition better? \_\_\_\_\_  
 \_\_\_\_\_

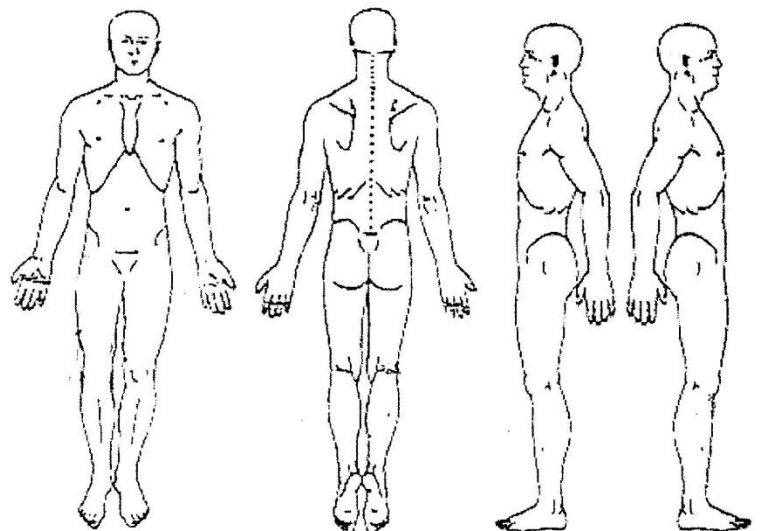
Since the injury are your symptoms:

Same \_\_\_\_\_ Worse \_\_\_\_\_ Improving \_\_\_\_\_ Variable \_\_\_\_\_

Please explain in more

detail: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What are your goals for treatment? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



## HEALTH HISTORY

Please list any diagnosed diseases or conditions: \_\_\_\_\_

Please list any surgeries you have received: \_\_\_\_\_

Please list any medications you are taking: \_\_\_\_\_

Please check all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Heart condition            | <input type="checkbox"/> Herpes/Shingles          | <input type="checkbox"/> Rashes, hives                      |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Eczema                             |
| <input type="checkbox"/> Blood clots                | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Psoriasis                          |
| <input type="checkbox"/> Bone loss                  | <input type="checkbox"/> Conjunctivitis           | <input type="checkbox"/> Bruising                           |
| <input type="checkbox"/> Water retention/swelling   | <input type="checkbox"/> Athletes foot            | <input type="checkbox"/> Allergies to lotions, salves       |
| <input type="checkbox"/> Headaches/Migraines        | <input type="checkbox"/> Other infectious disease | <input type="checkbox"/> Scented oils, nut based oils, etc. |

## DISCLOSURE STATEMENT

- I have listed all my known medical conditions and physical limitations and will inform my practitioner in writing of any change in my physical health between sessions.
- I am responsible for consulting a qualified primary care provider for any physical ailment that I may have.
- I understand that a massage practitioner must be aware of any and all existing physical conditions that I have in order to provide appropriate bodywork. I further understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or any other medical, physical or emotional disorder, nor performs any thrusting joint or spinal manipulations or adjustments.
- By Washington State law, it is illegal to request or engage in any sexual activity during or under the pretense of a massage session. I understand that upon such action, the session will end and will be reported to the authorities.
- I agree to give 24 hours notice if I must cancel my appointment. If a 24-hour notification of cancellation is not provided, I am responsible for payment in full.
- I agree that payment will be due in full at time of service.
- I understand that all information shared with my practitioner is confidential.

Signed \_\_\_\_\_ Date \_\_\_\_\_

# Information Disclosure Consent Form

## Kathy Scarpello, LMP

In this document, "I" and "my" refer to the patient, and "Practitioner" refers to Kathy Scarpello.

I consent to the use or disclosure of my protected health information by Practitioner for the purpose of analyzing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Practitioner. I understand that analysis or treatment of me by Practitioner may be conditioned upon my consent as evidenced by my signature below.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Practitioner describing the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Practitioner.

Practitioner reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Practitioner and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient

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Signature of Patient or Personal Representative

Date of Signing

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Description of Personal Representative's Authority

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## Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It applies to all protected health information contained in your health records maintained by me.

I am required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of my legal duties and privacy practices with respect to that information.

There are a number of **situations in which I may use or disclose** to other persons or entities your confidential health information, as is necessary for comprehensive treatment or to obtain reimbursement of my fees. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, I will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

**Treatment:** I will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom I need to consult with respect to your care.

**Payment:** I may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time.

You have certain **rights regarding your health record information**, as follows:

You have the right to inspect, copy and request amendments to your health records. I will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing. I will respond to your request in a timely fashion.

Revive Therapeutics  
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