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	TYPE OF PAIN	FREQUENCY
Minimal _____	Pins and Needles _____	Constant 24/7 _____
Mild _____	Numbness _____	Daily_____
Moderate _____	Burning _____	Weekly_____
Intense_____	Dull/Deep Ache_____	Intermittent_____
Severe _____	Stiffness/Tightness_____	Occasional_____
	Sharp/Stabbing _____	Only with specific movement _____

PLEASE MARK ON THE ILLUSTRATIONS BELOW <u>ANY</u> 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:_____

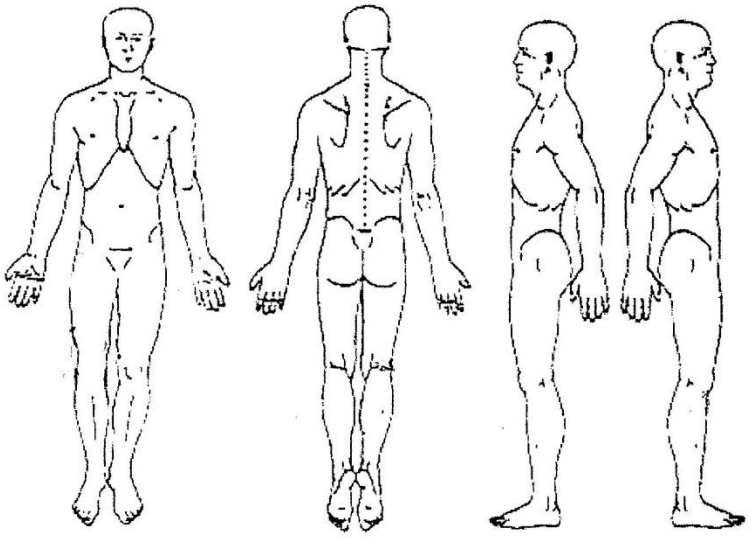
_____

_____

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:

____ Heart condition	____ Herpes/Shingles	____ Rashes, hives
____ High or low blood pressure	____ AIDS/HIV	____ Eczema
____ Blood clots	____ Hepatitis	____ Psoriasis
____ Bone loss	____ Conjunctivitis	____ Bruising
____ Water retention/swelling	____ Athletes foot	____ Allergies to lotions, salves
____ Headaches/Migraines	____ Other infectious disease	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 _____

Health Insurance Reimbursement Policy

Kathy Scarpello, LMP

I understand that I am responsible for all fees incurred as a result of my treatments with you.

I will keep a current physician's referral on file with you, regardless of whether my health policy requires it, and assume responsibility for making sure it is up to date. I understand that a physician's referral does not necessarily mean that the insurance company will reimburse you for your services.

Health insurance will pay for bodywork when it is "Medically Necessary", defined as restoring lost function due to illness or injury. They can and do deny payment when, in their view, the criteria are not met.

Insurance companies reimburse for **one hour** of treatment per visit. I understand that any extra time spent on a treatment is my personal financial responsibility and agree to pay the difference between the allowed rate and your regular fee, payable at the time of service.

I understand that I am personally financially responsible for all co-pays and deductible payments at the time of service. If my claims are denied, I will reimburse you within 30 days of denial.

I take responsibility for dealing with my insurance company if I disagree with their reasons for denied payment, and will pay you in a timely manner out of my own pocket until such time as the insurance company can be coerced into payment.

I have read and agree with all of the statements above.

Signature _____

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

_____

Signature of Patient or Personal Representative Date of Signing

_____ _____

Description of Personal Representative’s Authority

_____

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.

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