PHYSICIAN'S PRESCRIPTION / REFERRAL / MEDICAL NECESSITY #5a

FROM DOCTOR: DATE:
PHONE: FAX:

TO THERAPIST: **A BETTER WAY MASSAGE, LLC**
PH: 360-366-4216 FAX 360-778-1362

LOCATION AT 12 BELLWETHER WAY
SUITE 201, BELLINGHAM, WA 98225

REGARDING PATIENT _____, TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indicated below, using the modalities/procedures check-marked below that are within your scope of practice.

MODALITIES / PROCEDURES

PATIENT ID:_____

PATIENT PHONE #: _____

97124/97140____ MANUAL MASSAGE THERAPY TECHNIQUES
____ ACUPUNCTURE

DX CODES

- ☐ M54.2 CERVILALGIA
- ☐ M54.5 LUMBAGO
- ☐ M54.6 THORACIC SPINE PAIN
- ☐ M25.552 LEFT HIP PAIN
- ☐ M25.551 RIGHT HIP PAIN
- ☐ M25.512 LEFT SHOULDER PAIN
- ☐ M25.511 RIGHT SHOULDER PAIN
- ☐ R51 HEADACHE
- ☐ M25.522 LEFT ELBOW PAIN
- ☐ M25.521 RIGHT ELBOW PAIN
- ☐ M25.572 LEFT FOOT ANKLE AND JOINT PAIN
- ☐ M25.573 RIGHT FOOT ANKLE AND JOINT PAIN
- ☐ M25.532 LEFT WRIST PAIN
- ☐ M25.531 RIGHT WRIST PAIN
- ☐ M79.645 LEFT FINGER(S) PAIN
- ☐ M79.644 RIGHT FINGER(S) PAIN
- ☐ M25.562 LEFT KNEE PAIN
- ☐ M25.561 RIGHT KNEE PAIN
- ☐ M79.7 FIBROMYALGIA
- ☐ M79.1 MYALGIA

OTHER DX CODES
1._____
2._____
3._____
4._____

Treatment Plan:
#_____ Massages/Week for #_____Weeks

PHYSICIAN'S SIGNATURE_____

Referring Physician NPI# Required: _____

 # OF VISITS_____ **START DATE:** _____

THIS PRESCRIPTION/REFERRAL MAY BE FAXED TO MEDICAL RECORDS: 360-778-1362

11/29/2017

Bellingham Bellwether Location
Bayview Center
12 Bellwether Way, Suite 219
Bellingham, WA 98225
360-366-4216 F)360-366-4241

CONDITIONS OF TREATMENT/AGREEMENTS/CONSENT FORM

I understand the Financial Responsibility Research Form is located on abwmassage.com website and is available to me to research my insurance prior to my first appointment. I know I am responsible for payment of any deductible, co-payment and coinsurance as determined by my plan or program. I know you will collect these amounts at the time I get care. My insurance company may have additional requirements or limits that may affect my coverage like prior approval of care, visits, or other treatment limits. I agree to pay any amounts not covered by my health plan or program. If my plan does not cover any part of my care, or I choose to continue care beyond the limits of my health plan, I will be completely responsible for payment of care. I promise that the information I have provided is true and accurate to the best of my knowledge. I authorize my insurer or other benefit program to pay you directly for services you provide. I agree to pay the full amount of charges for care you provide me or the patient for whom I am financially responsible that remain after payment has been made by my insurer or other benefit program.

Questions About My Health Insurance: I will contact my insurance directly. My insurance company sends me the same Explanation that they send A Better Way Massage & Acupuncture showing Guarantor and Patient Responsibility.

Out of Network Billing: I understand I am responsible for the entire amount of the medical bill until A Better Way Massage & Acupuncture receive the reimbursement check and explanation of benefits that may have been received by me. I agree to deliver the reimbursement check along with a copy of the Explanation of Benefits to A Better Way Massage & Acupuncture in order for my bill to be reduced and the remainder be billed to me.

Missed Appointment Fee: I know you set aside time to provide me care; but, life can change suddenly and I might miss my appointment. If I don't give you at least 24-hours' notice in advance that I will miss my appointment, I will pay you $40 or the missed appointment which my plan or program will probably not cover and I will pay with my own money. There is a NSF fee of $20 per incidence charged to patient.

Prompt Pay at time of Service Discount*: I understand I have the option of prompt pay fee at time of service, however if I do not take this option at time of service and the insurance claim is returned with deductible at insurance maximum allowable amount, I will be billed stated amount and the rate WILL NOT BE REDUCED, unless otherwise agreed prior to service, to the prompt pay prices. The prompt pay at time of service is only allowed when payment is made at time of service.

Those who can use this discounted service are:

- Those who do not have insurance coverage, thus no insurance billing is required.
- Those who have a deductible and want to pay the prompt pay amount in lieu of the maximum allowable amount set by the insurance company. The facility will continue to send claim information to insurance, however prompt pay fee is required to be paid at time of service
- Those who provide proof of Medicare / Medicaid / Military Photo ID qualify for reduced rates.

I acknowledge that I have been offered to read, received, understand and agree to the terms and have been offered copies of the following documents, some of which are available at http://abwmassage.com/clinic-forms: (Please initial):

_____Patient Rights and Responsibilities (online/office)

_____Notice of Privacy Practices (online/office)

_____Consent to Release Information for Billing (online/office)

_____Financial Agreement (current/pt. reg)

_____Copy of this Document

_____HIPPA Notice Acknowledgement

_____Consent to **receive Cupping Therapy** (pt. reg)

_____Consent to Treat Massage/Acupuncture (pt. reg)

NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGEMENT - **This form will be retained in your medical record**
We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting your practitioner. Our **Notice of Privacy Practices** describes in more detail how your health information may be used or disclosed, and how you can access your information.

I certify the information given by me is correct. I have read and consent to the terms of the agreements above by initialing. I am the patient, or I am authorized as the patient's agent or representative to execute the above. I accept its terms on behalf of the patient, or assume individually all financial responsibility by my signature. I have been given a copy of this agreement.

_____Date_____
Patient/Patient Representative Signature

Print Patient Name:_____

A Better Way Massage & Acupuncture

New Patient Registration

Today's date:	**Your Primary Care Practitioner/Physician:**

PATIENT INFORMATION

Patient's last name:	First:	Middle Initial:	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐M ☐F

Street address:	Social Security:	Home phone : ( )

City:	State:	ZIP Code:	Email:	Cell phone : ( )

Occupation:	Employer:	Employer phone: ( )

Were you referred to our Office? ☐ Yes ☐No If yes, by whom?

(***Mark all that apply***) **You may leave voice mail *appointment reminders* at:** *Home:* ☐ *Work:* ☐ *Cell:* ☐ *Text:* ☐

You may send *general information* and *appointment reminders* by Email or Text Message noted above: ☐ Email:	**You may share *general information* with the following person:** (relationship)

INSURANCE INFORMATION (***Please show or provide a copy of your insurance card and photo identification***)

Person responsible for bill:	Birth date: / /	Address (if different from above):	Home phone: ( )

Occupation:	Employer:	Employer address:	Employer phone: ( )

Is this patient covered by insurance? ☐ Yes ☐ No	Name of Primary Insurance :

Subscriber's name:	Subscriber's S.S.:	Birth date: / /	Group number:	Policy number:	Co-payment: $

Name of secondary insurance (if applicable):	Subscriber's name:	Group number:	Policy number:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Cell phone: ( )

1. I understand that I am responsible for charges not covered or reimbursed by my health plan or similar payer. I agree to pay you directly if my insurer, health plan, employer program or similar benefit program does not pay. I am responsible for a $40 missed or late arrival fee, and $50 charge for each NSF or returned check.
2. I authorize my insurer, health plan, employer program or similar benefit program to release information to you regarding my coverage.
3. My right to payment for care, treatment, supplies and other services are hereby assigned to you. This assignment covers any and all benefits under Medicare, other government sponsored programs, insurance, employer programs and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. If my insurer, health plan, employer program or similar benefit program does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to you.
4. I understand and **authorize release** of all health information about me to my insurer, health plan, employer program or similar benefit program identified above **to obtain payment** for care, treatment, supplies and other services. The above information is true to the best of my knowledge.

Patient/Guardian signature *Date*

For Office Use Only (Rev. 1.0)

Date Received: _____ File Reference #: _____ Action: _____

Person Acting: _____ ☐ Response/ Date: _____ ☐ Filed Without Response

New Patient Intake - MASSAGE THERAPY

Patient Name _____ **Date** _____

A BETTER WAY MEDICAL MASSAGE ACUPUNCTURE

General Information

Address _____ City _____ State _____

Home Phone _____ Occupation _____ Zip _____

Work Phone _____ SS# _____ Date of Birth _____

Mobile Phone _____ E-mail _____

Emergency Contact _____ Relationship _____ Phone _____

Family Physician _____ Phone _____

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

If you were referred to us, who referred you? _____

Insurance Information

Which type of insurance do you have? ☐ Private Health Insurance ☐ ~~Auto Accident~~ ☐ Labor & Industries

IF AUTO ACCIDENT - PLEASE STOP AND USE MVA HEALTH INTAKE FORM ON OUR WEBSITE.

If you wish for our office to bill your private insurance please provide a copy of your insurance card. Once your insurance coverage has been verified we will be glad to accept payment directly from the insurance company. By signing below you acknowledge that there is no guarantee of payment from your insurance company and all charges are your responsibility.

Health History

Current	Past	**Head**
☐	☐	Headache
☐	☐	Concussion
☐	☐	Whiplash

		Muscles & Joints
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoarthritis
☐	☐	Scoliosis
☐	☐	Disk Degeneration
☐	☐	Herniated Disk
☐	☐	Ruptured Disk
☐	☐	Lupus
☐	☐	Tendonitis
☐	☐	Bursitis
☐	☐	TMJ, Jaw Pain
☐	☐	Fibromyalgia

		Endocrine System
☐	☐	Thyroid Dysfunction
☐	☐	Diabetes
☐	☐	Bladder/Kidney Dysfunction

Current	Past	**Skin Conditions**
☐	☐	Rashes
☐	☐	Warts
☐	☐	Athletes Foot

		Nervous Systems
☐	☐	Dizziness
☐	☐	Ringing in Ears
☐	☐	Loss of Memory
☐	☐	Sciatica

		Cancer/Tumors
☐	☐	Benign
☐	☐	Malignant
☐	☐	Other _____

		Digestive System
☐	☐	Endometriosis
☐	☐	Irritable Bowels
☐	☐	Crohn's Disease
☐	☐	Other _____

Current	Past	**Allergies**
☐	☐	Lotions
☐	☐	Detergents
☐	☐	Other _____

		Cardiovascular/Respiratory
☐	☐	Heart Disease
☐	☐	Blood Clots
☐	☐	Stroke
☐	☐	Heart Mummer
☐	☐	Chest Pain
☐	☐	Lymphedema
☐	☐	Poor Circulation
☐	☐	Swollen Ankles
☐	☐	Varicose Veins
☐	☐	High/Low Blood Pressure
☐	☐	Other _____

		Reproductive System
☐	☐	Pregnancy (# of weeks: _____)
☐	☐	Fibrotic Cysts
☐	☐	Abdominal Pain
☐	☐	Other _____

A BETTER WAY MASSAGE & ACUPUNCTURE o) 360-366-4216 f) 360-366-4241
FERNDALE OFFICE: 7056 PORTAL WAY R7, FERNDALE, WA 98248 WWW.ABWMASSAGE.COM
BELLINGHAM BELLWETHER OFFICE: 12 BELLWETHER WAY, SUITE 201 , BELLINGHAM, WA 98225

Health Report

Have you recieved massage therapy before? ☐ No ☐ Yes – How often?

Do you currently have any infectious/contagious diseases? ☐ No ☐ Yes – Please explain:

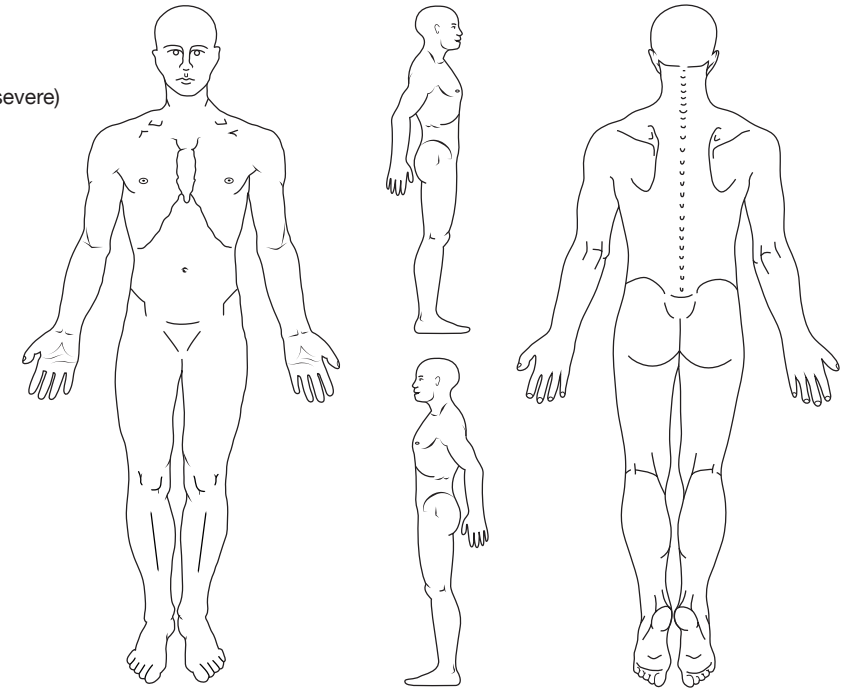
List all skin conditions:

List surgeries and broken bones:

List all current medications:

Instructions:
1) Circle the areas that are bothering you today
2) Write the letter in the circle to describe what you are feeling
3) Rate the feeling on a scale from 1-10 (1: mild, 5: moderate, 10: severe)

P: pain
T: tension/stiffness
N: numbness/tingling
A: ache
B: burning
HA: headache
O: other (explain)



Consent for Care

- It is my choice to receive manual therapy, and I give my consent to receive treatment.
- I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.
- I understand manual therapy is not a substitute for medical examination or diagnosis.
- I understand that massage practitioners do not diagnose illness or disease, nor prescribe medical treatment, pharmaceuticals, or perform manipulations.
- I understand that my manual therapist reserves the right to stop the massage at any time if deemed necessary.
- I give my permission for my therapist to speak with my referring health care provider regarding my care.

I confirm that the above information is correct to the best of my knowledge

Signature _____ Date _____

Signature of Parent or Guardian if patient is a minor

MASSAGE CUPPING CONSENT TO TREAT BELOW:

• Information has been provided to me about Cupping Therapy. If I choose to experience these therapies during treatments, I understand the potential effects and after-care recommend
• It has been explained to me that there are contraindications for Cupping Therapy. I have fully disclosed all health factors to my therapist, including those not mentioned on my Health History Intake Form, to avoid any complications.
• It has been explained to me that there is the possibility of discolorations that can occur from the release and clearing of stagnation and toxins from my body.
• I also understand that this reaction is not bruising, but due to cellular debris, pathogenic factors and toxins being drawn to the surface to be cleared away by my circulatory and lymphatic systems.
• I further understand that the discolorations will dissipate from a few hours to as long as 2 weeks in some cases and in relation to my after-care activities.
• I understand that Cupping Therapy modalities should not be combined with aggressive exfoliation, 4 hours after shaving, after a sunburn or when hungry or thirsty.
• I understand that I should avoid exposure to extreme cold, wet, and /or windy weather conditions, hot showers, baths, saunas, hot tubs and aggressive exercise for 24 hours. It has been explained to me that exposure to such extremes can produce undesirable effects and I should avoid such situations.
• I understand that I should avoid caffeine, alcohol, sugary foods and drinks, diary and processed meats and I should consume an abundance of clean water.

I agree to allow the Cupping Practitioner to perform Cupping. I also agree that I have read, understand and will follow all of the information stated above and will not hold the practitioner responsible.

SIGNATURE: _____