

### CONFIDENTIAL QUESTIONNAIRE FOR MASSAGE

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ / Preferred Pronouns \_\_\_\_\_ / Marital Status  S  M  
 Occupation \_\_\_\_\_ Email \_\_\_\_\_  
 Referring Provider: Name \_\_\_\_\_ Phone \_\_\_\_\_

#### Insurance Information

If you have auto or L&I coverage, please also list any medical coverage.

<input type="checkbox"/> Auto	<input type="checkbox"/> L&I/Workers' Comp	<input type="checkbox"/> Medical
Insurance Company _____	Insurance Company _____	Insurance Company _____
Address _____ _____	Address _____ _____	ID # _____
Claim # _____	Claim # _____	If you are not the primary insured, give the primary insured's: Name _____
Claim Adjustor _____	Claim Adjustor _____	
Phone & Extension _____	Phone & Extension _____	Date of Birth _____
Date of Injury _____	Date of Injury _____	ID # _____
Attorney Name _____		

**Please read and sign:**

- I acknowledge that the above information is complete and accurate to the best of my knowledge, and I will notify Paul Perrotta & Associates of any changes.
- I agree to the release of any information for medical and insurance purposes and authorize PP&A to obtain any information from my healthcare providers concerning my health.
- I am aware that I am fully responsible for all healthcare bills for services rendered. An unpaid balance is due 30 days from invoice date. A \$15 rebilling fee plus 1% interest or a minimum of \$1 will be charged until balance due is paid. Returned checks will be charged \$25. Additional court, attorney or collection agency fees may be charged if applicable.
- For a missed appointment or cancellation with less than 24 hours notice, I will be charged \$65.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (or Guardian)

## Message Billed to Insurance

Dear Massage Client,

Here are some important things to know about billing your insurance company for your massage.

### You Are Responsible for Payment

- Whenever you receive treatment at our office, you are ultimately responsible for the cost.
- Your insurance plan is a contract between you and your insurance company. Your insurance company has the final say on what is covered and not covered under your plan.
- If your insurance company does not pay for your care or takes payment back because it determines the care was not covered, you are responsible for paying. We will bill you at our self-pay rate.

### Know Your Benefits

- Even though we may verify eligibility or coverage for you, it is your responsibility to know your coverage. Contact your insurance company with any questions about your coverage.
- Plans differ, even within the same insurance company. Typical limits for massage coverage include (these are examples; your plan may differ):
  - Massage may be covered only to improve an underlying physical condition or disability that causes acute or sub-acute (not chronic) symptoms or functional limitation.
  - Massage may not be covered to maintain the current status, to provide temporary pain relief without improving the underlying condition, to relieve stress, or to promote wellness.
  - Massage coverage may be combined with other rehabilitation coverage (such as physical therapy), and rehabilitation may be limited to a certain number of visits per year.
  - Members are not entitled to coverage up to their visit limit if their care does not meet other requirements of their plan.
  - The plan may conduct a medical review during or after a member's care to determine whether the care is/was covered and may deny payment or take payment back.

### Get and Maintain a Valid Prescription

- Some plans require a prescription or referral for massage. Others do not explicitly require this, or they say you can self-refer. If we will be billing your insurance, we require that you provide a prescription or referral. Why?
  - When we send a claim to your plan on your behalf, we must state the diagnosis for which you are receiving massage. It is not within a massage practitioner's scope of practice to diagnose.
  - Most plans require massage to be medically necessary. A prescription or referral from a qualified provider may assist you in documenting that massage is medically necessary for you.
- Your prescription must be dated on or before the date of the first massage that you want covered. It must state the diagnosis codes for which you are receiving massage and the number of visits.
- Your plan may have other requirements for what your prescription must say or who can write it. Check with your insurance company to find out exactly what you need.

Please let us know if you have any questions.

Thank you,  
Paul Perrotta & Staff

\*I have read and agree to the above.

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Signature

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Date

(Office Staff & LMPs: Keep original in client file.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

### Health History

Have you ever experienced any of the following?  
 Use "C" for current, "P" for past, "S" for sometimes.

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV             | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Sciatica          |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stiff Joints      |
| <input type="checkbox"/> Amenorrhea           | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> Skin Allergies    |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Digestive Problems    | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Sprain/Strain     |
| <input type="checkbox"/> Athlete's Foot       | <input type="checkbox"/> Disc Problems         | <input type="checkbox"/> Menstrual cramps    | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Diverticulitis        | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Swollen Feet/Legs |
| <input type="checkbox"/> Back Pain            | <input type="checkbox"/> Eczema                | <input type="checkbox"/> Muscle Spasm        | <input type="checkbox"/> Tendonitis        |
| <input type="checkbox"/> Bone Fracture        | <input type="checkbox"/> Epilepsy/Seizures     | <input type="checkbox"/> Numbness            | <input type="checkbox"/> Tingling          |
| <input type="checkbox"/> Bursitis             | <input type="checkbox"/> Excess Stress         | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Tumor             |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Excessive menstrual   | <input type="checkbox"/> PMS                 | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Chronic Fatigue      | bleeding                                       | <input type="checkbox"/> Pregnant/trying to  | <input type="checkbox"/> Whiplash          |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Fibromyalgia          | become pregnant                              | <input type="checkbox"/> Other             |
| <input type="checkbox"/> Colitis              | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Psoriasis           | _____                                      |
| <input type="checkbox"/> Clenching/Grinding   | <input type="checkbox"/> Heart Attack/Ailments | <input type="checkbox"/> Rash                | _____                                      |
| Jaw   | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Ringworm            | _____                                      |

Have you had any accidents, injuries or surgeries?  
 Less than 5 years ago \_\_\_\_\_  
 \_\_\_\_\_  
 More than 5 years ago \_\_\_\_\_  
 \_\_\_\_\_

Are you currently receiving medical or chiropractic care?  Yes  No  
 If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_

Are you currently taking any medications (prescription or over-the-counter)  Yes  No  
 If yes, please explain \_\_\_\_\_  
 \_\_\_\_\_

Do you wear hard contacts?  Yes  No

Lifestyle	Heavy	Moderate	Light	None
Exercise	_____	_____	_____	_____
Stretching/Self-Care	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____

What type of exercise? \_\_\_\_\_ How often? \_\_\_\_\_

Have you received massage before?  Yes  No  
 What did you especially like? \_\_\_\_\_  
 \_\_\_\_\_

What did you especially dislike? \_\_\_\_\_  
 \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (or Guardian)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

### Present Complaints

Please describe your current problem \_\_\_\_\_

How did the problem begin? \_\_\_\_\_

When did it begin? \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

How often are your symptoms present?

- Constantly  Frequently  Occasionally  Intermittently

Any range of motion restrictions? \_\_\_\_\_

Can you perform your daily *home* activities?  without pain  with pain

Explain \_\_\_\_\_

Can you perform your daily *work* activities?  without pain  with pain

Explain \_\_\_\_\_

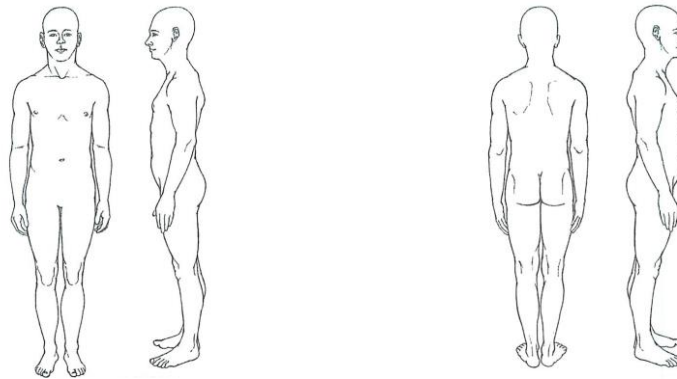
How is the quality of your sleep? \_\_\_\_\_ Average hours of sleep per night \_\_\_\_\_

What treatment(s) have you had for this condition? \_\_\_\_\_

What are your goals with massage therapy? \_\_\_\_\_

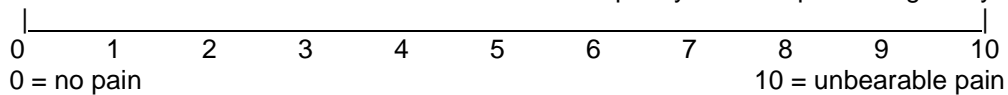
#### A. Draw today's symptoms on the figures.

- Identify CURRENT symptomatic areas in your body by marking letters on the figures below.  
**P** = pain or tenderness, **S** = joint or muscle stiffness, **N** = numbness or tingling
- Circle the area around each letter to show the size and shape of each symptom location.

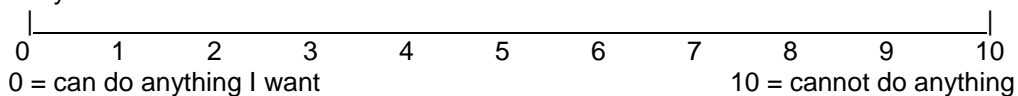


#### B. Identify the intensity of your symptoms.

- Pain scale: Mark a line on the scale to show the amount of pain you are experiencing today.



- Limitations scale: Mark a line on the scale to show the limitations you are experiencing today in your daily activities.



Patient Signature \_\_\_\_\_ Date \_\_\_\_\_  
(or Guardian)

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**LMP:** Provide laminated copy of notice of privacy practices to client for review.

**Client:** Complete the portion below.

I, \_\_\_\_\_ (client name), have received the notice of privacy practices from Paul Perrotta Massage Associates.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**LMP:** If client was given the notice but did not sign, complete the portion below.

In lieu of client signature, I, \_\_\_\_\_ (LMP name), of Paul Perrotta Massage Associates state that \_\_\_\_\_ (client name) has been given the notice of privacy practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date