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.

❑ Auto	❑ L&I/Workers' Comp	❑ Medical
Insurance Company ____________	Insurance Company ____________	Insurance Company ____________
Address ____________ ____________	Address ____________ ____________	ID # ____________
Claim # ____________	Claim # ____________	If you are not the primary insured, give the primary insured's:
Claim Adjustor ____________	Claim Adjustor ____________	Name ____________
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)

Massage 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.

______________________________ ____________________
Signature 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.

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

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)

Paul Perrotta & Associates
Ph 206-729-8000 | Fax 206-260-7999

Last Name ______________________________ First Name ______________________________

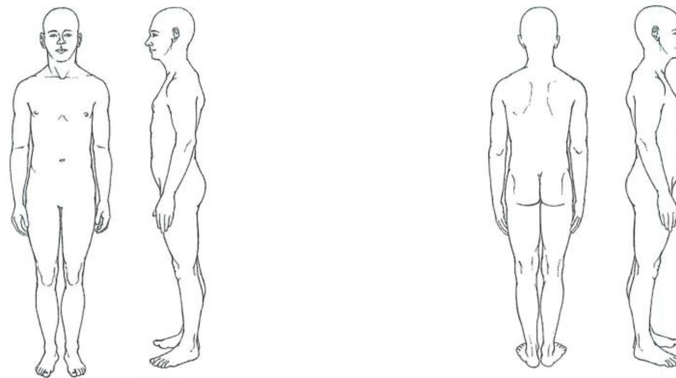
Present Complaints

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.

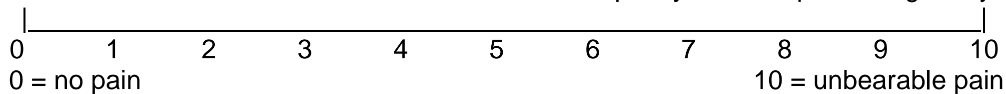
1. Identify CURRENT symptomatic areas in your body by marking letters on the figures below.
   P = pain or tenderness, **S** = joint or muscle stiffness, **N** = numbness or tingling

2. Circle the area around each letter to show the size and shape of each symptom location.

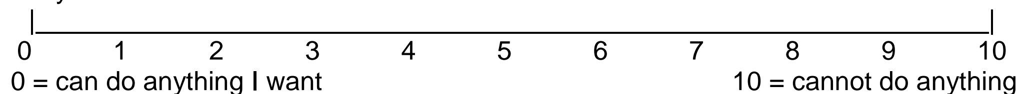


B. Identify the intensity of your symptoms.

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



2. 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