Welcome Wellness Massage Therapy P.C.

Petrina DeRobertis LMT

Patient Information Form:

Name: _____

Gender: M_____ F_____ D.O.B_____/_____/_____

Home Address: _____
(Street, Apt #) (City) (State) (Zip)

Home Ph: (_____)_____ Cell: (_____)_____

The phone number you provide will be used to confirm appointments via text/Call: (_____)_____

Email: _____ Employer: _____

Address:_____
(Street) (City) (State) (Zip)

Emergency Contact: _____Phone: (_____)_____

Relationship to you: _____ Who Referred you to us: _____

List of Medications:_____

_____

_____

Insurance Information

_____*Not going through insurance*

The insurance information questions are necessary. Please provide your insurance ID card for Photocopying. Thank you.

Insurance Company: Name _____ Phone(_____)_____

Insured's ID# _____ Group # _____DOB___/___/____

As a service to our patient, Petrina DeRobertis LMT will submit charges for medical treatment to the patient's insurance company. However, the patients is primarily responsible for paying any and all medical expenses incurred at this office.

We may attempt to verify in advance that the patient's insurance company will pay for the specific medical procedures. Occasionally, even though coverage was verified before medical services were provided, the insurance company denies the claim. If the insurance company denies payment or will not pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his/her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible, in addition to whatever amounts the insurance does not pay.

I agree to be responsible for payment of services in the event my insurance company doesn't agree to pay for these services. Not signing this document does not release your responsibility of payment

I authorize my card on file to be charged each month (Co Pays/Co Insurance), including any fees that may apply, and wave my right to charge back against the merchant any monthly charges, dues or fees for the duration of your treatments.

_____ _____

Patient or Authorized Person's Signature **Date**

1305 Middle Country Rd
Selden, NY 11784

(631)880-3810

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Medical History and Symptom/ Pain Information

Please provide reports with the verbiage if possible

Chief Complaint:	**Today's Pain Scale**	**New Injury Or Old Injury**	**MRI Date**	**CT Scan Date**	**X-Ray Date**
#1_____	____/10	_____	_____	_____	_____
#2_____	____/10	_____	_____	_____	_____
#3_____	____/10	_____	_____	_____	_____

Do you have an official Diagnosis for these complaints?_____

What have you tried to help with the complaints? What were the outcomes?

_____

_____

_____

Are you Pregnant? _____ **How Many Months?** _____

Please Put a Check indicating Yes or No for the following…….

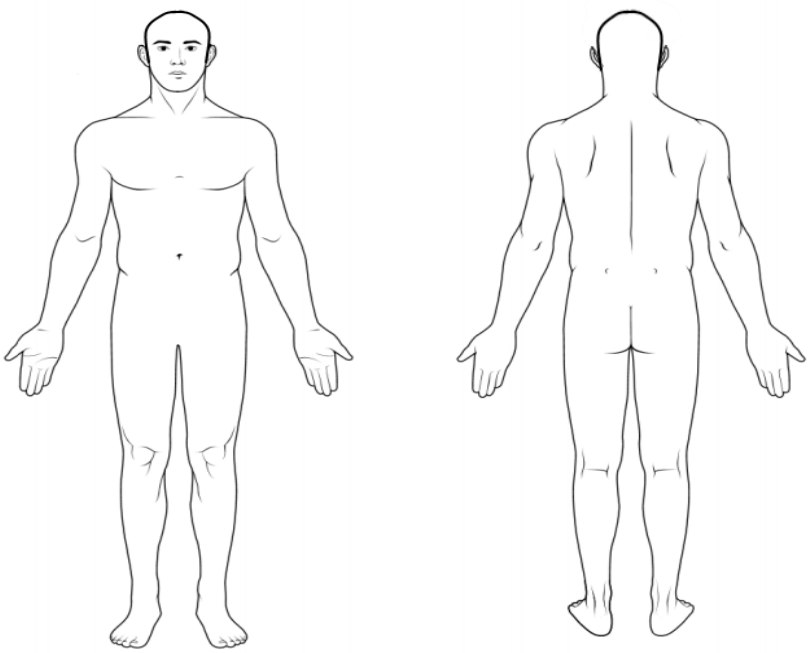
	Yes	**No**
Do you have a pacemaker/defibrillator……	_____	_____
Are you on Blood Thinners……	_____	_____
Have Diabetes……	_____	_____
If Yes, Type 1_____ or Type 2_____		
Have Vertigo or Experience Frequent Dizziness……	_____	_____
Have history of Headaches/Migraines……	_____	_____
Have Had Surgery/surgeries……	_____	_____
If Yes,Please write what surgery and the date(s)		

_____

_____

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

[P.] Pain
[T.] Tingling
[N.] Numbness
[B.] Burning
[S.] Stiffness
[Th.] Throbbing
[Sh.] Shooting
[St.] Stabbing
[A.] Achy



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Information and Consent to Services

I have read and understand this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risk and benefits of the service(s) to be preformed have been explained to me. I have also received the Notice of Privacy Practice and the accompanying will be used and disclosed consistent with this notice, and that I have the right to request restrictions on certain questions regarding the proposed services and other pertinent information, including questions about him or her, and I have received satisfactory explanations.

Disclosures For Massage Therapy

Services to be provided

I understand that massage therapy services individuals with a range of complaints including both acute and chronic healthcare issues.

Risks, Possible Side Effects and Healing Response

I understand that massage therapy may result in certain side effects, including local bruising, temporary pain and discomfort, and temporary aggravation of symptoms existing prior to treatment. Generally, the healing response will subside within 72 hours. It is the responsibility of the patient to inform the practitioner of any treatment reactions as soon as possible.

Other Professional Competencies

I am aware of other bodywork modalities and understand that I have consented to the specific service of massage therapy as noted above. I understand that should I need such additional care that my practitioner may offer referrals to a separately licensed professional.

NO Guarantees

I know that each person is unique and has ultimate responsibility for his or her own healthcare. I acknowledge that I have not received any guarantee or promises as to the results or success that will be obtained from the services provided.

Infectious Disease Prevention

I know that infectious diseases are carried through the air, though physical contact, and through body fluids. I understand that me, practitioner, follows universally prescribed precautions and procedures (such as hand washing and sterilization of equipment) to prevent the spread of infectious diseases.

Patient responsibilities

I understand that it is my responsibility as a patient to inform my practitioner about all aspects of my health and that as the services progresses, to inform my practitioner of changes that occur. If I experience any pain or discomfort during the treatment, I will immediately inform the practitioner so that treatment may be adjusted to my level of comfort.

_____ _____

Patient or Authorized Person's Signature **Date**

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Information Consent for Massage Therapy Treatment and Care

I hereby request and consent to the performance of massage therapy treatment and other complementary medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by Petrina DeRobertis LMT.

I understand that the methods of treatment may include, but not limited to: massage therapy, cupping, slide cupping, guasha, supplement recommendations, and nutritional counselling.

Massage Therapy is the manipulation of the muscles and other soft tissues of the body (as by stroking, kneading, or rubbing with one or both hands or an instrument) by a massage therapist for therapeutic purposes (as to relieve pain, promote healing, or improve physical functioning). I have been informed that massage therapy is a safe method of treatment, but occasionally there may be some bruising or soreness that last a few days. There may be some bruising after cupping. There could also be a reaction or sensitivity to massage oils.

I understand that I am responsible for telling my massage therapist about any allergies I may have and my massage therapist is not responsible for any allergic reactions that may occur.

I understand that massage therapy should not be considered a substitute for a medical examination, diagnosis, or treatment and that I should see a physician or other qualified healthcare specialist for any mental or physical ailment for which I am aware.

I understand that a massage therapist does not diagnose illness or disease and does not prescribe medical treatment or pharmaceuticals nor are spinal manipulations part of massage therapy.

I do not expect the massage therapist to be able to anticipate and explain all risks and complications. I wish to rely on the therapist to exercise judgment during the course of procedure, which the therapist feels at the time, based upon the facts then and known, is in my best interests.

I understand the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I Have read, or have had an opportunity to ask questions about its content.

I understand my patient records and patient information will be kept confidential and shred only when necessary to provide care and services, or by my authorization, or when required or permitted by law.

By signing below, I agree to the above- named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name: _____

Patient's/ Patient Representative's Signature: _____

Date _____/_____/_____

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Practitioner/ Patient Agreement

*Are you currently in a **No Fault** Case?* *Yes_____ No_____*

If Yes…..

Name of Insurance Company:_____

Date of occurrence:_____

Case # assigned:_____

What is the name of the insurance company's representative in charge of your case

Name:_____ Phone #:_____ Email address:_____

*Are you currently in a **Workers Comp** Case?* *Yes_____ No_____*

If yes……. WORKERS COMP **DOES NOT** Pay for Acupuncture, but we still need to know what codes your current care practitioners are using/billing under to make sure not to interfere with your case. Your practitioner will NOT be treating you for the same condition as what your workers comp case will be billing for.

If you answered no to both of these questions…….

I,_____ am signing this agreement stating I DO NOT currently have an open No Fault/Workers Comp case. I have NOT withheld this information from my practitioner. If a new case happens AFTER signing this agreement and your practitioner is NOT informed, than they are NOT liable/responsible for providing notes to a case they did not know existed.

Patient Name:_____ Practitioner's Name:_____

Signature:_____ Signature:_____

Date:_____ Date:_____