bellwellness
TRACY M. BELL, MA LMT NCTMB
95 Allen's Creek Rd. Bild 1 Suite 312, Rochester NY 14618
585.406.0127

PATIENT INTAKE FORM: INFORMATION FOR ASSESSMENT AND TREATMENT

PERSONAL INFORMATION

Name______________________________Date of Birth:________________Phone:____________________

Address______________________________City/Zip Code________________ Email:____________________

Emergency Contact (name and Phone number)?____

Occupation?______________________________Whom may we thank for the referral ________________

HEALTH INFORMATION

INSURANCE CO. **POLICY/CLAIM NUMBER**

❑BlueCross/Shield______________________
❑MVP-CIGNA______________________
❑AETNA:______________________
❑No Fault:______________________

*Primary Care Physician:*______________________________

First Massage or Body Treatment? ❑*yes* ❑*no*

Date of your last Massage or Body Treatment? ________________

Preferred Pressure: ❑*light* ❑*medium* ❑*deep* ❑*unsure*

Reason for visit____

Areas that need attention today? ____

Any Pain associated? ❑*yes* ❑*no* Describe ____

Please list any surgeries, injuries or accidents and dates: ____________________________________

____

Medications: ____

Please check all that apply: **Mark appropriate stress zones**

Respiratory
__ breathing problem(lung)
__ sinus problems
__ Allergies

Musculoskeletal
__ tendonitis
__ Bursitis
__ sprains/strains
__ broken/fractured bones
__ bruise easily
__ spasms/cramps
__ carpal tunnel
__ shoulder/neck problems
__ low back pain
__ joint pain/degeneration
__ jaw pain/TMJ
__ sciatica
__ arthritis

Nervous System
__ herpes/shingles
__ numbness/tingling
__ chronic pain
__ fatigue
__ sleep disorder

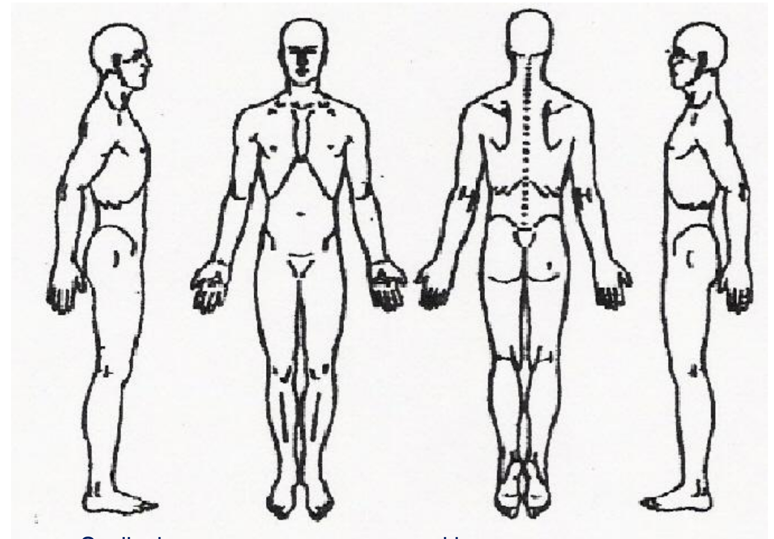
Mental/Emotional
__ suffer from stress
__ depression
__ anxiety
__ insomnia

Circulatory
__ heart problems
__ varicose veins
__ high blood pressure
__ arteriosclerosis
__ migraines

Skin
__allergies
__Rashes
__athletes foot
__warts

Reproductive
__ pregnant or nursing
__ PMS or menopausal
__ fibroid tumors

Other
__ Fibromyalgia
__ Multiple Sclerosis
__ Lupus



__ Scoliosis
__ diarrhea/constipation/IBS
__ diabetes
__ epilepsy
__ cancer

__ smoking
__ jaundice / hepatitis
__ exercise
__ contact lenses
__ last consumption of alcohol

INFORMED CONSENT

The above information is accurate to the best of my knowledge. I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand this does not deter me from seeking medical treatment for medical conditions. I agree to inform the therapist of any experience of pain during the session.

I understand that massage therapy is not a substitute for medical examination, diagnosis and treatment, and that I should see a medical or chiropractic doctor or other health care specialist for those services. Because massage should not be performed under certain circumstances, I agree to update the massage therapist in regard to health changes and I release the massage therapist from any liability if I fail to do so.

PAYMENT/CANCELLATION POLICY

I understand that **twenty-four hour notice must be given** when canceling appointments. I agree to pay for the session when less than twenty-four hour notice is given for non-emergencies. I understand that I am **allowed one no-show visit** and that I must **prepay for all further appointments**.

PAIENT SIGNATURE *(BELOW)*.	DATE	THERAPIST SIGNATURE	DATE

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FINANCIAL AGREEMENT

I, ________________________________ (patient), understand that the *no fault insurance* is an *agreement between the insurance company* and *myself*. I understand that Tracy Bell, health care provider, will *assist me in billing my insurance carrier for services* provided to me.

However, I am fully responsible for any payments due that are denied by my insurance company. I assign payments to be made on my behalf to this provider for any services furnished to me.

I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services. If the bills for services are not paid within sixty (60) days by my insurance carrier, I am responsible for the balance on the balance on the sixty-first (61st) day.

In the event fees are not paid as requested, I hereby authorize the health care provider to charge all past due payments to my credit card listed below. I understand that upon payment I will receive a receipt for submission to my insurance company for reimbursement. In the event fees are not paid as requested, a collection agency and possibly legal action may follow.

If so, I ____________________________(patient), will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I have read and understand this financial agreement.

______________________________ ______________________________
Patient Signature Date Signed

Print Name of Cardholder as it appears on Credit Card:____________________________
Credit Card Number:

▢▢▢▢-▢▢▢▢-▢▢▢▢-▢▢▢▢

Expiration Date: ▢▢/▢▢ Security Code: ▢▢▢ Billing Zip Code: ▢▢▢▢▢

CANCELLATION – NO SHOW POLICY

We value our relationship with our patients. This policy has been established to prevent misunderstandings.

1. The policy of this office is that a no show by a client always results in a cost to this office.
2. New York State law does **not** allow this office to charge any **insurance company** for any appointment that is missed by a patient undergoing treatment for a no-fault or workers' compensation injury.
3. However, a **patient may be held personally responsible** for missing appointments since missed appointments impact a.) the viability of the provider office and b.) impacts and adversely affects the treatment plan and contract of care established by the provider office.
4. Accordingly, this office will hold all patients personally liable for any no show appointment. **A no show appointment is defined as any missed appointment or appointment that is canceled with less than 24 hours notice.**

Office number: 585-406-0127

I have read the above statements and understand.

______________________________ ______________________________ ____________
Patient Signature Print Name Date Signed

(WComp / NoFault only)

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Insurance Information

Patient's Relationship to Subscriber ☐Self ☐Spouse ☐Child ☐Partner ☐Other ___________

Insured's Name:____________________________Date of Birth:__________Phone:__________________

Address________________________________City:____________________State:____ZIP Code ____

Date of Injury:_________Diagnosis: 1) _______ 2)_______ 3) ________ 4) ________

Client Status: ☐*Single* ☐*Married* ☐*Divorced* ☐*Unemployed* ☐*Employed* ☐*FT Student* ☐*PT Studen*

Referring Physician:______________________Phone:____________________Fax:________________

Address________________________________City:____________________State:____ZIP Code ____

Insurance Provider: Workers Comp (specify company)____

Motor Vehicle (specify company)____

WC/NF Address________________________________City:______________State:___ZIP Code ____

WC/NF Adjuster Name:___________________________Phone__________________Ext.__________

Policy #: _________________________Plan/Group: ______________**Claim #:** ___________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (if possible, someone not living at same address) ____________________________

Relationship to Patient:_________________________________

Home Phone No. ________________________ Work Phone No. _________________________

The above information is true to the best of my knowledge and I authorize treatment. I authorize my insurance benefits to be paid directly to Tracy Bell MA LMT. I understand that I am financially responsible for any balance. I also authorize Tracy Bell MA LMT or insurance company to release any information required to process my claims.

_____________________________ _____________________________

Patient Signature Date Signed

Insurance Assignment and Release of Benefits

I certify that I, and/or my dependent(s), have insurance coverage with ____________________________
Name of insurance company(ies)
and assign directly to Tracy Bell MA LMT all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that there may be a limit to the number of visits my insurance allows and will pay the hourly rate per visit when exceeding that limit.

The above-named practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

_____________________________ _____________________________

Patient Signature Date Signed