The Good Life Massage

200 S Tobin St, Ste A
Renton, WA 98058
425-243-7705
www.goodliferenton.com

New Client Welcome Packet

We welcome you to our clinic! Enclosed you will find all the paperwork needed for your first visit. As you are using an insurance claim through PIP or L&I as payment for your sessions, we must have all the required paperwork in order to properly submit billing.

New Client Paperwork
Client Intake Form
Insurance Waiver & Information
Activities of Daily Living Assessment
Medical Records Release Form

Documents you must provide
Doctor's Referral massage - This can be a referral, but sometimes it looks like a prescription. It must give a reason (diagnosis) for why you are seeking massage, including ICD-10 codes for this reason/diagnosis.

If this paperwork is incomplete, or you do not have your referral at your first appointment, ***you will be responsible*** for payment of that session as we cannot submit billing for your claim without that documentation.

Please note that insurance companies will not pay for missed appointments, which includes last minute cancellations. You will be responsible for the payment of these sessions, so please make sure to review our cancellation policies before scheduling your appointments.

We look forward to helping you on your health journey. If there is anything we can do to help you in this process, please email us at support@goodliferenton.com or by calling 425-243-7705.

Kylee Davis & Amy Gunn
Co-Owners, LMTs

Tom Gunn
Billing Coordinator

The Good Life Massage – Client Intake Form

Please print legibly

Name: _____ Email: _____

Address: _____ City, ST Zip: _____

Preferred phone: _____ Birthday: _____

Referred to this office by: _____ Occupation: _____

Emergency contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Massage/Bodywork Information

On a scale from 1 to 10, 10 = highest, rate your average levels of:

Stress: _____ Pain: _____ Energy: _____

How did your symptoms begin & when did they start? _____

Is your condition getting better/worse? _____

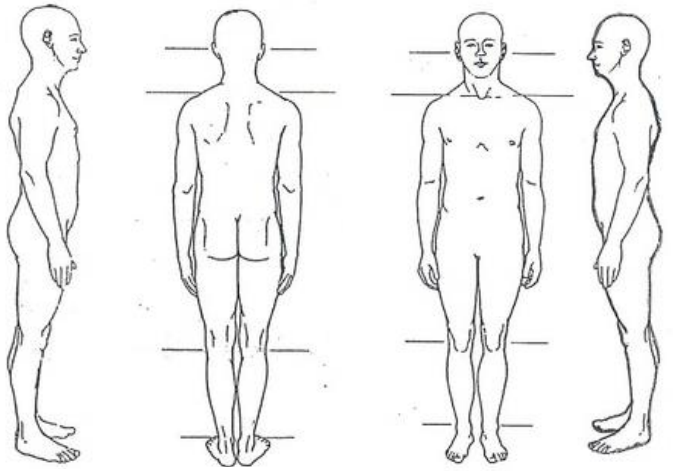
What have you done for relief? _____

What are your massage or bodywork goals? _____

What kind of pressure do you prefer?

☐ Light
☐ Medium
☐ Firm
☐ Deep

On the diagrams to the right, mark any areas where you are experiencing tension (T), pain (P) and/or discomfort



General/Medical Information

Y N Have you ever had a professional massage? If yes, how often? _____

Y N Are you pregnant? If yes, how far along are you? _____ **Additional form required*

Y N Are you sensitive to touch/pressure in any area? Ticklish? Bruise easily? _____

Y N Do you have sensitive skin or allergies (essential oils, nut oils, fragrances etc.)? If yes, please list: _____

_____

List of current medications we should know about: _____

_____

List accidents/injuries within the last years (Surgeries, whiplash, sprain, other): _____

_____

_____

Medical Info (cont.) – Please check all that apply:

- ☐ Skin condition – Rash, warts, hives, skin cancer, other: _____
- ☐ Lymphatic condition – Swollen gland, lymph edema, Chronic congestion: _____
- ☐ Joint issues – Stiffness, Arthritis, sacroiliac problems, TMJ, other: _____
- ☐ Bone condition – Osteoporosis, fracture, other: _____
- ☐ Headaches – Type & Frequency: _____
- ☐ Major surgeries – Type and Date: _____
- ☐ Circulatory condition– Varicose veins, blood clots, high blood pressure (Are you taking medication?): _____
  _____
- ☐ Numbness/tingling, Nerve disorders: _____
- ☐ Tendinitis, tendinosis or bursitis: _____
- ☐ Diabetes: _____
- ☐ Epilepsy/Seizures: _____
- ☐ Contagious diseases: _____
- ☐ Other medical conditions/medications we should know about? _____

Massage Client Waiver

Please take a moment to read and initial all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my Licensed Massage Practitioner (LMP) so that pressure/strokes can be adjusted to my level of comfort. I will not hold my LMP responsible for any pain or discomfort I experience during or after the session. _____

I understand that the services offered today are not a substitute for medical care. I understand that my LMP is not qualified to perform skeletal adjustments, diagnose, prescribe or treat physical or mental illness. I affirm that I have notified my LMP of all known medical conditions and injuries._____

I agree to inform my LMP of any changes in my health/medical condition. I understand that there shall be no liability on the LMP's part should I forget to do so. By signing this release, I hereby waive & release my LMP from any liability past, present and future relating to massage therapy and bodywork._____

I understand that massage is entirely therapeutic and non-sexual in nature. I also understand that any illicit or sexually suggestive remarks or advances I make will result in immediate termination of the session, and I will be liable for payment of the appointment. _____

I understand that if I cancel my session between 24 and 4 hours prior to my appointment, I'll be charged 50% of the cost of the massage. If I forget or choose to miss my appointment, or call to cancel less than 4 hours prior to my session start time, I will be charged the full value of the massage. If I do need to cancel my session, I'll try to do so more than 24 hours prior to my appointment time to avoid any charges. _____

I understand that I can request a copy of my records at any time per the Health Insurance Portability & Accountability Act (HIPAA). Requests will be granted within 30 days of written notice and a nominal fee may be charged for copying requested records. Everything discussed with my LMP is confidential and cannot be discussed with anyone unless I provide written consent. _____

Client Signature: _____ Date: _____

LMP Signature: _____ Date: _____

The Good Life Massage – PIP or L&I Claim Disclosure

Please print legibly

Date of injury: _____ PIP ☐ L&I ☐ Claim #_____

Case Manager/Insurance Agent Name: _____

Case Manager/Insurance Agent Phone: _____

Referring Practitioner: _____ Phone: _____

Please also provide a copy of their referral/prescription with diagnosis codes

I, (print name) _____ , agree to pay the full cost for all sessions not covered by my claim or denied after submission.

Signature _____ Date_____

Clinic Use Only:
Billing Fax number: _____ CMS 1500 ☐ Invoice ☐

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Activities of Daily Living Assessment

Please assess how your pain or injury affects the following activities by rating them. Use the charts below to track your activities.

Date: _____

Name: _____

0 = No disturbance due to pain/injury
L = Light due to pain/injury
M = Moderate due to pain/injury
S = Severe due to pain/injury

Activity	This Past week	Activity	This Past week
Sleeping		Standing for long periods	
Personal Care		Ability to exercise	
Driving Car		Other (specify):	
Work			
Recreation		Other (specify):	
Lifting Heavy objects			
Walking			

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Authorization for Use/Disclosure of Health Information

Authorization for Use/Disclosure of Information: I voluntarily consent to an authorize my healthcare provider _____ (insert name) to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

Recipient: I authorize my healthcare information to be released to the following recipient(s):
Name: The Good Life Massage PLLC
Address: 200 S Tobin St Ste, A Renton, WA 98057
Phone: 425-243-7705
Fax: 425-979-4200

Purpose: I authorize the release of my health information for the following specific purpose: _____.
(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

☐ All of my health information that the provider has in his or her possession, relevant to my injury or claim for massage therapy at this time.

☐ Only the following records/types of health information: _____.

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of _____, 20___.

☐ Until the billing of my claim is completed in its entirety.

Authorization for Use/Disclosure of Health Information (cont.)

Reciprocity: I authorize The Good Life Massage to communicate with the following health care provider, as needed for my continued care under this claim:

Name: _____

Address: _____

Phone: _____

Fax: _____

_____ _____

Signature Date

_____

Printed name

If Individual is unable to sign this Authorization, or is a minor, please complete the information below:

_____ _____

Signature Date

_____ _____

Printed name Relationship to client