Oxford Wellness Clinic

Massage Patient Health History Form

Name: _____

Address: _____

City: _____ Postal Code: _____

E-mail Address: _____

Phone Number: (daytime) _____ (evening) _____

Birth date:_____ Occupation: _____

Hobbies/Recreation: _____

MEDICAL DOCTOR: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

Name: _____

Phone number: _____

ALLERGIES: _____

Please list all of your previous injuries and when they occurred: _____

_____

Please list any recent surgeries (within the last 12 months): _____

_____

Are you taking any medications, herbs, or supplements? If so, please specify: _____

_____

Where did you hear about this clinic? _____

Are you pregnant? If yes, what is your due date (DD/MM/YYY): _____

Are you trying to get pregnant? _____

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Do you have, or have you had, any of the following? Please check all that apply:

Cardiovascular:
___ High/Low Blood Pressure
___ Varicose Veins
___ Blood Clots
___ Swelling of the hands/feet
___ Heart Condition
___ Anaemia

Respiratory:
___ Asthma
___ Bronchitis
___ Sinus Problems
___ Allergies
___ Sleep Apnea
___ Emphysema

Skin:
___ Psoriasis
___ Eczema
___ Excessive Dryness
___ Rash(es)
___ Athlete's Foot

Muscle/Joint Pain:
___ Neck
___ Shoulder
___ Elbow
___ Back
___ Wrist/Hands
___ Hip
___ Knee
___ Ankle/Foot

Nervous System:
___ Numbness
___ Tingling
___ Carpal Tunnel
___ Neuralgia
___ Parkinson's
___ MS

Other:
___ Diabetes
___ Cancer
___ Fibromyalgia
___ Fatigue
___ Osteoporosis
___ Haemophilia

Are you currently experiencing any pain or discomfort? If so, please explain: _____

_____

Do you have any other illnesses, ailments or conditions *not* previously listed? If so, please list:___

_____

I _____ understand that the Massage Therapist is not a physician and cannot diagnose any physical or mental illnesses. I understand that it is recommended that I continue to see my physician for any ailment I might be experiencing. I acknowledge that no guarantee has been made to me as to the results of the treatment.

I have completed my health history form as provided by my Massage Therapist and I have disclosed all medical conditions that are affecting me. The information I have provided is true and complete to the best of my knowledge.

I understand that none of my information will be released without my written consent.

I understand that the treatment may cause some discomfort at times and I acknowledge that I, and the therapist, can discontinue the treatment(s) at any time.

*Signature:*_____ *Date:*_____

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CANCELLATION AND NO SHOW POLICY

Our office requires a minimum of **24 hours** notice for cancellations of any massage appointments. Failure to notify the clinic before **24 hours** or not showing up for you allotted time will result in a **No Show Fee** of $50.
No show fee cannot be direct billed to any insurance company payment must be made prior to any future massage treatments.

I have read and fully understand and agree to the above fee and no show/cancellation policy.

_____
Patient Name

_____
Patient Signature

_____

Date

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Electronic Transmission Authorization and Consent Form

Message to the Plan member, Spouse and/or Dependent regarding Personal Information
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and *I* or plan abuse.

Authorization and Consent
I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and *I* or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
  Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only
I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider{s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

Date: _____ **Patient Signature:** _____

Print Name: _____