GREENWAYCOTTON CHIROPRACTIC and Body Harmony Massage

Dr. William Bucur—16995 W Greenway Rd. Suite 102/Surprise, Az 85388/623-433-8895

MASSAGE REGISTRATION

HOW DID YOU HEAR ABOUT OUR OFFICE? **Please Circle One.**

Community Event, Mailing, Door Hanger, Internet, Patient Referral - Name: _____

Other: _____

Patient First Name & Nickname (if applicable):		**Middle Initial:**	**Last Name:**		
Address:		**City:**	**State:**	**Zip:**	**Home Phone:**
Cell Phone:	**Cell Carrier:**	**Email:**	**Birth Date:** / /	**Sex:**	

Please check if you object to receiving any of the following:

Monthly office newsletter _____ **Happy Birthday card _____** **Any Other mailings _____**

PARENT OR GUARDIAN OF MINOR (under 18 yrs)Person Responsible For Payment

First	**Middle**	**Last**	
Address:	**City:**	**State:**	**Zip:**
SSN#:	**Birth Date:**	**Phone:**	

I VERIFY AND ACKNOWLEDGE THAT ALL INFORMATION IS CURRENT AND CORRECT (PLEASE SIGN BELOW).

Patient Signature or Parent/Guardian:	**Date:**

HIPAA Privacy Rule

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Greenway/Cotton Chiropractic "Notice of Privacy Practices Abridged Edition" has been provided to me. I understand I have a right to review the entire Greenway/Cotton Chiropractic Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Greenway/Cotton Chiropractic. The Notice of Privacy Practices for Greenway/Cotton Chiropractic also, is provided on request at the main administration desk of this practice. This Notice of Privacy Practices also describes my rights and Greenway/Cotton Chiropractic duties with respect to my protected health information.

Greenway/Cotton Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name: _____ **DOB: _____**

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Name: _____ **Date of Birth:** ____/____/____

Have you received massage therapy before? Yes ___No___

What type of pressure do you prefer? Light ___Moderate ___Deep ___Not sure___

What is your occupation? _____

What are the expectations/goals for this massage session? _____

Have you had any current surgeries? _____ (within the last 2 years)

Explain: _____

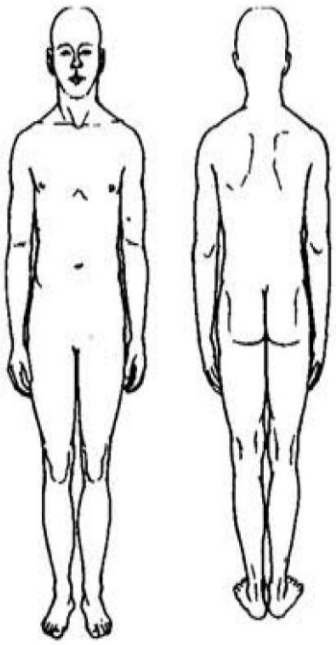
Do you have any allergies to oils or lotions? _____sensitive skin (y/n)? _____

Are you pregnant? _____how many weeks? _____

Do you have any of the following (circle)

Abdominal Pain	Fibromyalgia	Anemia
Accident	Headaches	Jaw Pain/TMJ
Allergies	Heart Disease	Multiple Sclerosis
Arthritis	High Blood Pressure	Osteoporosis
Bursitis	HIV	Pacemaker
Gout	Joint Pain	Parkinson's Disease
Broken Bones	Lower Back Pain	Hernia
Blood Clots	Mid Back Pain	Glaucoma
Cancer	Nervous Tension	Hypertension
Colitis	Sprains/Strains	Bronchitis
Diabetes	Stroke/Seizures	Pinched Nerve
Disc problems	Varicose Veins	Prosthesis
Sinus Problems	Tendonitis	Thyroid Issues
Tumors or Growths	Ulcers	Whiplash

Please indicate areas you feel discomfort or need



Medications: _____

_____

Primary Physician: _____Phone #:_____

Emergency Contact: _____Phone #:_____

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My initials indicate that I have read and agree with each item below.

Professional Fees

_____ Any payment will be due in full at the time of service.

_____ All initial appointment fees are due upon first day of service. Special financial arrangements must be discussed by the second appointment.

_____ A $25 processing fee will be charged for any NSF fees on each return of payment.

_____ A fee will be charged for missed appointments and cancelled appointments inside of 24 hours.

- $20 charge for 1 Hour massage
- $10 charge for 30 min massage

All payments will be processed to the credit card on file that same day. Late arrivals to sessions may require to be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, you will be responsible for "full cost" of the cost of that session. Out of respect and consideration for your therapist and other customers, please plan accordingly and be on time.

Authorization of Release of Records

I authorize the release of any medical information necessary to process my claim and/or for better treatment in this office including x-rays, MRIs, Lab tests, etc.

PATIENT ACKNOWLEDGEMENT

By signing my name below, I acknowledge receipt of the above stated notice and my understanding and agreement to its terms.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Authorization

I_____, give authorization to the following individuals listed below to:

Communicate with Greenway Cotton Chiropractic by way of text, email, or phone on my behalf to discuss my schedule, reschedule or cancel appointments. ( ) yes ( ) no

Communicate in regards to billing and results pertaining to my care with Greenway Cotton Chiropractic.
( ) yes ( ) no

Name: _____

Relationship: _____

Name:_____

Relationship: _____

Patient Name: _____ **DOB:** _____

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Informed Consent to Massage Services

- **I hereby consent to massage therapy to be performed by affiliate Massage Therapist within the office and acknowledge that if I experience any pain or discomfort within the massage session**
- **I have read, or have had read to me, the above consent. I consent to the opportunity to ask questions about its content, and 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. I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort.**
- **I further understand that Massage Therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.**
- **Because Massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.**
- **Cupping/Gua Sha: I understand that cupping therapy will leave bruise-like marks that will last several days depending on the severity of my condition. While most marks fade and disappear after a few days, there are times when marks could take up to 15 days to clear and in rare cases, it has been reported that marks have taken up to 21 days to fully clear.**
    - **Contraindications: 1. Hemophilia or other bleeding/clotting disorders 2. Patients taking blood thinners 3. Weak patients or those who have been ill 4. Abdomen and lower back on pregnant women 5. Diabetics. Especially those with uncontrolled blood sugar as they may not be able to feel pain properly 6. Those who are unable to experience heat or pain properly 7. Those who have circulatory conditions *8. Those who are unsure if their condition is contraindicated should seek guidance from their primary care physician prior to receiving cupping therapy.***
    - **I understand that bruising, discoloration and/or soreness will likely occur following this treatment and may take days or weeks to fully resolve. I further understand that the above-listed conditions are contraindicated for cupping therapy and I have informed my therapist/physician of any and all medical conditions, even those not listed as contraindications. I further understand that there is a potential for burns and/or blisters due to the fire/heat aspect of the treatment. This is a rare but not unexpected occurrence. (Initials) _____**
- **Improper Conduct: This is a Therapeutic Massage session and any sexual remarks or advances will terminate the session and understand I will be liable for payment of the scheduled treatment. I understand the Massage Therapist practitioner reserves the right to refuse services to me for any reason that the Therapist deems necessary. Male and *female* modest will be considered will not be exposed or touched at any time. Professional draping will be used for your privacy and comfort. Our policy requires therapists to leave the room prior to disrobing/undressing and use draping with sheets/ blankets at all times during every massage session. (Initials) _____**

Print Patient Name: _____

Signature of Patient: _____ **Date:** _____

Consent to Treatment of a Minor: By my signature below, I hereby authorize the spa and its therapists to provide massage and related services to my minor child or dependent as we deem necessary. Additionally, I have read, verified, and agree with all information on this form. I understand that I may be present during any massage received by child. This authorization is valid until and unless it is revoked by me in writing. Name of Parent or Guardian (please print):

_____

Patient/Parent/Guardian Signature_____ **Date** _____

Witness/ Personnel: _____**Date:**

Patient Name: _____ DOB: _____