Welcome to West Chester Acupuncture and Chiropractic

2019 Massage Therapy Payment Agreement

Our office will verify your insurance benefits as a courtesy for you. However, a verification of benefits is never a guarantee of payment from the insurance company. For this reason, our office needs patients to sign a payment agreement to guarantee payment for their services. If for any reasons your insurance does not cover the services rendered, then you will be financially responsible for the entire amount owed to Dr. Hilbert, and/or Dr. Young.

In addition our office requires a 4 hour cancellation notice for all massage services or a fee will occur.

You must call or leave a message at the office at least 4 hours prior to your appointment to avoid a fee. You will be charged one of the according fees below on your credit card the same day that the late/missed appointment occurs. Reminder calls are done as a courtesy; you are ultimately responsible for keeping your appointment. If you are running late please call the office so that we may inform your massage therapist. There is no fee for being late however; your massage time may be cut short due to the schedule.

The fees for a missed or late cancellation of a massage are as follows:

30 Minute Massage ($20.00) 60 Minute Massage ($35.00) 90 Minute Massage ($45.00)

By signing below, I agree to these terms:

_____ _____

Patient Signature Date

_____

Print Name

2019

WEST CHESTER ACUPUNCTURE AND CHIROPRACTIC
DR.JULIE HIBERT AND DR. BURTON YOUNG
7665 MONARCH COURT, SUITE 110, WEST CHESTER, OHIO 45069
513.777.9428 (FAX) 513.777.3628

West Chester Acupuncture and Chiropractic

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.
7665 Monarch Ct. Suit 110 West Chester OH, 45069 - 513-77-9428

Medical Intake Form For Massage

Date: _____

Please take a moment to complete the following questionnaire. This will help to ensure a safe and comfortable massage session for you. All information is confidential.

Have you received massage in this office in the past? ( ) Yes ( ) No If yes, please inform the therapist before continuing.

Full Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____

E-mail: _____

Emergency Contact: _____

Relationship to you: _____ Phone #: _____

PCP: _____ Phone #: _____

Do you give permission to contact your Physician: ( ) Yes ( ) No

Have you ever had a massage before: ( ) Yes ( ) No If yes, when? _____

Do you smoke? ( ) Yes ( ) No Do you consume alcohol? ( ) Yes ( ) No

Do you have any areas that you want specific attention? _____

Do you have allergies to any skin oils, lotions or fragrances: ( ) Yes ( ) No If yes, explain? _____

_____

Are you currently taking any blood thinners?

❑ Coumadin ❑ Lovenox ❑ Heparin ❑ Any Pain Medication: _____

Are you taking any cancer medication? ? ( ) Yes ( ) No

If yes, please list: _____

Are you taking any muscle relaxants? ? ( ) Yes ( ) No

If yes, please list: _____

Have you taken any medications in the last 24 hours? ( ) Yes ( ) No

If yes, please list: _____

Have you had surgery within the last 5 years? ( ) Yes ( ) No

If yes, what & when: _____

Have you had any implants within the last 9 months? ( ) Yes ( ) No

If yes, what & when: _____

Do you currently have any of the following?

- ❑ Acute inflammatory conditions (ex. Phlebitis or Cellulites)
- ❑ Arthritis/ Tendonitis (Stenosis, Spondylitis or Spondylolisthesis)
- ❑ Blood clots
- ❑ Blood thinners (Coumadin, Heperin, Aspirin 325mg/day)
- ❑ Breast implants within last 9 months
- ❑ Broken/cracked ribs
- ❑ Cancer - list below type, benign or active
- ❑ Chemotherapy or radiation therapy
- ❑ Depressed immune system (Lupus, Epstein, Barr, Mononucleosis, HIV/AIDS)
- ❑ Diabetes (Insulin pump? Yes or No)
- ❑ Dialysis (need MD's written permission)
- ❑ Fever
- ❑ Fibromyalgia
- ❑ Fractures/dislocations- list below type and when
- ❑ Hemorrhoids
- ❑ Herniated or protruded discs (Area: _____)
- ❑ High blood pressure
- ❑ Injections recently at joint or muscle junctures
- ❑ Injuries – list below type and when
- ❑ Irritable Bowel Syndrome
- ❑ Joint surgery, joint replacement (ex. Steel rods)
- ❑ Kidney or Liver disorder (including Dialysis)
- ❑ Neck/back injuries
- ❑ Neuropathy (from disease or chemo)
- ❑ Osteoporosis
- ❑ Pacemaker/heart conditions
- ❑ Scoliosis
- ❑ Skin – boils, skin lesions or abscesses, psoriasis, acute conditions, acne, skin cancer, shingles, burns, eczema, recent surgery by dermatologist – list below
- ❑ Sprains/strains
- ❑ Surgery – list below any recent surgeries
- ❑ TMJ dysfunction
- ❑ Tuberculosis, Thrombosis or Aneurysm (circle)
- ❑ Varicose veins

Note: Clients who have undergone any surgery including Lasik eye surgery must avoid massage for 72 hours. Massage must be avoided by anyone who has consumed alcohol within 24 hours of appointment. If you have had a heart condition that required surgery, pacemaker, stint or shunt you will need to avoid massage for one year and you will need written approval from your surgeon in the form of a permission slip.

List any necessary details or additional information the therapist may need to know.

_____

_____

_____

*Please note, if we may be of any assistance with chiropractic care, please do not hesitate to schedule an appointment. There is no charge for a consultation. This allows you time to speak with the doctor about your health concerns. If you are currently receiving chiropractic care, some insurance companies cover massage therapy if recommended by the doctor.

Massage Therapy Informed Consent

I, _____, understand that the massage therapy provided by the licensed massage therapist is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion and improve circulation.

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that the massage therapy is not a substitute for medical diagnosis, medical treatment or medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions, and medications and I will keep the massage therapist updated on any changes. I give my consent to receive the treatment.

_____ _____

Client Signature Date