CONFIDENTIAL CLIENT INTAKE FORM

dream**clinic** ™

PERSONAL INFORMATION

Name ______________________________ Date ______________________

Address ______________________________ City ________________ State ________ Zip __________

Primary Phone ________________ Secondary Phone ________________ Date of Birth ________________

Email Address ________________________ How did you hear about us? ________________________

Employer ______________________________ Occupation ______________________________

Emergency Contact ______________________ Emergency Contact Phone ______________________

MASSAGE HISTORY / TREATMENT INFORMATION

Have you ever received a professional table massage? ☐**Yes** ☐**No** Date of last massage ________________

List any exercise and stress reduction activities and frequency: ______________________________

____

Are there specific areas of your body you want the massage to focus on today? ________________

____

What results do you want from your massage sessions? ______________________________

____

PREVIOUS HISTORY

Allergies: ____

Surgeries: ____

____

Injuries/Accidents: ____

____

Major Illnesses or other hospitalizations: ______________________________

____

Are you currently seeing a medical practitioner? ☐ Yes ☐ No If yes, please give name and location:

____

If necessary, do we have permission to consult with your medical practitioner? ☐ **Yes** ☐ **No**

Are you currently seeing a psychotherapist or attending support group meetings? ☐ **Yes** ☐ **No**

Please explain if yes: ____

____

List current medications, including aspirin, ibuprofen, etc. ______________________________

____

Cancellation Policy:

Dreamclinic requires at least **24 hours' notice** if you need to cancel or reschedule your appointment for any reason. For no-shows or cancellations with less than 24 hours' notice, Dreamclinic, Inc. will charge a cancellation fee.

As a courtesy to your massage therapist, if you arrive late for your appointment, your session will be billed the full rate while we may have to shorten the duration of the session.

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Please identify any of the following, which you now have or have had in the past:

Now	Past		Now	Past		Now	Past	
		Skin Conditions			**Nervous System Conditions**			**Digestive Conditions**
❑	❑	Rash	❑	❑	Numbness	❑	❑	Constipation
❑	❑	Allergy	❑	❑	Tingling	❑	❑	Diarrhea
❑	❑	Fungal Infection	❑	❑	Nerve Damage	❑	❑	Ulcer
❑	❑	Other	❑	❑	Shingles	❑	❑	Other
			❑	❑	Other			
		Muscle Conditions						
❑	❑	Strain			**Respiratory Conditions**			**Other Conditions**
❑	❑	Tendonitis	❑	❑	Sinus			
❑	❑	Spasm	❑	❑	Lung / Bronchial	❑	❑	____________________
❑	❑	Cramp	❑	❑	Other			
❑	❑	Other				❑	❑	____________________
					Circulatory Conditions			
		Joint Conditions	❑	❑	Heart	❑	❑	____________________
❑	❑	Sprains	❑	❑	Blood Pressure			
❑	❑	Arthritis	❑	❑	Arteries	❑	❑	____________________
❑	❑	Degenerating Joints	❑	❑	Veins			
❑	❑	Other	❑	❑	Other			

I have listed all my known medical conditions such as surgeries, injuries, diseases, physical limitations and medications and will inform the massage therapist of any change in my physical health between massage sessions. I understand that a massage practitioner must be aware of any existing physical conditions that I have in order to provide appropriate massage.

I also understand that a massage practitioner neither diagnoses nor prescribes for illness, disease, or any other medical, physical or emotional disorder, nor performs any thrusting joint or spinal manipulations or adjustments. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have.

I understand that massage does not involve any form of touch of genitalia or nipples and I understand that these areas will be draped at all times during the massage. Should the massage practitioner not be clear and acting differently from these expectations, I agree to speak to him or her any time I feel my wellbeing is being compromised.

TRANQUILITY SERVICES

Dreamclinic Tranquility Services are designed to help create a more relaxed state in the body and mind, much like meditation. It is considered safe in most instances, however, on rare occasions, mild side effects have been reported, such as slight drowsiness, vertigo or feeling of nausea during or after the first session. Adjusting the volume or positioning the chair in a more upright position may minimize these effects. Furthermore, the service may not be advisable in the presence of severe acute inflammation (excluding normal flu), major internal or external bleeding, and in cases of severe heart disease. Please consult with your physician before undergoing a vibroacoustic session if you are at risk of heart attack, have a pacemaker or are pregnant.

I understand the above potential risks and participate in vibroacoustic sessions at my own risk.

My signature below indicates that I have read and understand all the statements above.

Client Signature ____ **Date**__________________________

DREAMCLINIC, INC.
CONSENT / RELEASE OF RECORDS/
ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT

CONSENT: **Client Initial Here________**

I, the undersigned, hereby authorize the staff of Dreamclinic, Inc. to examine and perform procedures that are considered therapeutically necessary on the basis of findings during the initial exam and the course of treatment.

RELEASE OF RECORDS: **Client Initial Here________**

To Dreamclinic, Inc.: I hereby authorize you and your chosen medical billing service, to release to any attorney, physician, State Insurance Commissioner, or insurance company, involved in my case, any medical or other records or information necessary to process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury/illness sustained on (date) ____/____/____.

ASSIGNMENT OF BENEFITS: **Client Initial Here________**

To Insurance Company______________________________: I hereby direct and instruct you to make payment directly to the undersigned provider(s) for medical claims submitted by them on my behalf for medically necessary treatment.

Your denial or delay to do so in a timely manner will be considered just cause for the provider or me to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned provider to file this complaint on my behalf if deemed necessary.

CANCELLATION POLICY: Client Initial Here________

I understand that at least **24 hours notice** is required for cancellation or rescheduling of appointments. For no-shows or cancellations with less than 24 hours notice I will be charged a standard cancellation fee. For visits where I am late, I will be charged a portion of said fee. My insurance will not be responsible for these charges.

PAYMENT AGREEMENT: **Client Initial Here________**

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that Dreamclinic, Inc. is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to it for my medically necessary care and treatment.

I understand that Dreamclinic, Inc. charges the following rates for Medical Massage and Acupuncture (latest rates are on www.dreamclinic.com): Massage: $33-$38 per unit (one unit is 15 minutes) and Acupuncture: $45-$60 per unit. Medical massage fees are based upon industry standard rates for Manual Therapy. Actual reimbursement rates vary due to Insurance companies' variances in allowable rates. I understand these charges are different from and above rates charged for Wellness services that are paid by clients directly.

I agree and acknowledge that I am ultimately responsible to Dreamclinic, Inc. for payment of any balance due and any cancellation fees that may arise. Balances may include any unpaid deductible, co-insurance, or co-payment due to Dreamclinic, Inc. according to my policy coverage in the event the clinic is unable to collect from my insurance carrier or attorney, in the case where Dreamclinic, Inc. is holding an attorney lien on my behalf

I, ___________________________________, a patient seeking health care, have assigned insurance benefits to Dreamclinic, Inc., a health care provider, for services rendered to me by him/her. In addition to assigning payments to said health care provider, I have signed a financial agreement with said health care provider stating that I shall be fully responsible for any payments due to said health care provider that are denied by my insurance company.

I have been given the opportunity to read the above CONSENT / RELEASE OF RECORDS/ ASSIGNMENT OF BENEFITS / PAYMENT AGREEMENT form, to ask questions concerning it, and have received an adequate explanation of it.

CLIENT NAME____

CLIENT SIGNATURE________________________________**DATE**_____/_____/_____

Revised May 2014

Notice to Clients – Dreamclinic, Inc. Massage and Acupuncture Privacy Practices

Dreamclinic is dedicated to excellence and integrity for the massage and bodywork profession. Our licensed massage therapists (LMPs), licensed acupuncturists (LAcs) and staff are expected to follow appropriate professional standards for maintaining client confidentiality. Our confidentiality and privacy practices are as follow:

Client Records

Client records are maintained in a confidential manner, kept in a file folder which is to be secured in a locked file when not in use by the LMP, LAc or being reviewed by Dreamclinic, Inc. staff for administrative purposes.

Client Rights

Clients may request, in writing to see or obtain a copy of their records. The client may request that corrections be made if they identify errors or mistakes. Access to records will be made during regular business hours within 30 days of receipt of written request and a fee may be charged for copying and sending requested records. Requested records are sent standard US Mail unless the client requests they are sent via express mail (at client's expense). Records are not available by email.

Use of Records

Dreamclinic, Inc. LMPs and LAcs maintain client records. No records are released without the written authorization of the client unless compelled by law. LMPs and LAcs use client records when providing massage and acupuncture services to individual clients. Client records may be discussed and reviewed by Dreamclinic, Inc. staff for insurance purposes or treatment planning.

Disclosure of Records

All Dreamclinic, Inc. LMPs and LAcs are provided access to client records since the client may be seeing more than one therapist. At no time are client records and information released to anyone outside of Dreamclinic, Inc. without written request and release from the client unless compelled by law (such as subpoenas), or for insurance billing.

Privacy Officer Contact Information

Larisa Goldin, LMP and President
Dreamclinic, Inc.
916 NE 65th St.
Seattle, WA 98115
206.267.0863
service@dreamclinic.com

I (please print) ______________________________ have received, read and understand this privacy policy as it relates to receiving massage from a Dreamclinic LMP or an acupuncture treatment from a Dreamclinic LAc.

Client Signature____ Date___________________