How did you find us?

CHECK THE BOX THAT INDICATES HOW YOU HEARD ABOUT US

- ❑ Friend or Family Member:(Name)_____
  - ❑ If "friend or family member," did they buy you a gift certificate? **YES NO**
- ❑ Medical Professional:(Name and Title) _____
- ❑ Advertising: Television Radio Outdoor ad Y. Pages Other:_____
- ❑ Internet: our website Facebook Instagram Twitter Yelp Google search Google Reviews Other:_____
- ❑ Community Event: (specify where you saw us)_____
- ❑ Other: (Please specify)_____
- ❑ I am a returning customer: (what kept you away?)_____

Contact Information

(If Client is under 18, this form should be completed by parent or guardian)

First Name:_____ Last Name:_____ Date of Birth:_____

Address:

_____

City: _____State: _____ Zipcode: _____

Email Address:_____Home Phone Number: _____

Cell Phone Number: _____Cell Phone Provider:_____

Work Phone:_____Occupation: _____

Preferred Method of contact (Please Circle One): Email or Text Message

Personal Health Information

(If Client is under 18, this form should be completed by parent or guardian)

PERSONAL DATA

First Name:_____MII:_____Last Name:_____ Birth Date:_____

Occupation:_____Employer:_____Today's Date:_____

Family Doctor:_____Permission to Consult with Physician? Initial if Yes:_____

Emergency Contact:_____ Relationship:_____
Phone#:_____

MASSAGE HISTORY / TREATMENT INFORMATION

Have you ever received professional massage therapy ?:_____ If Yes, how often?:
_____
Date of last massage:_____ . What Results do you want to get from your massage session(s)?:

Prioritize the areas of your body that you would prefer to be massaged:

Please circle the areas of the body you give permission to be massaged:

Back	**Hips**	**Upper Chest**	**Face**
Upper Legs	**Glutes/Buttocks**	**Neck**	**Feet/Hands**
Lower Legs	**Abdomen**	**Head**	**Arms**

In the Past 24 hours, have you had (A) a fever **YES NO** (B) any infection illness, cold, or flu (even if mild) **YES NO**

Are you currently seeing a medical practitioner?:_____ If Yes, please explain:

Are you currently involved in psychological counseling or regular support group meetings?_____
If Yes, please explain:

Please list stress reduction and exercise activities, including frequency:

Please list current medications, including aspirin, ibuprofen, etc:

PREVIOUS HISTORY

Please list past surgeries, including dates:
Please list past accidents, including dates

Client Health History

(If Client is <18 years old, this form must be completed by parent or guardian)

Please check all that apply and explain below:

	MUSCULO-SKELETAL
	Bone or Joint Disease
	Tendonits
	Arthritis
	Low Back/Hip/Leg Pain
	Neck/Shoulder/Arm Pain
	Headaches/Head Injuries
	Spasms/Cramps
	Jaw Pain/TMJ
	Lupus
	Broken Bones
	Specify:
	Sprains/Strains
	Specify:
	Other/Elaborate:

	CURCULATORY
	Heart Condition
	Varicose Veins
	Blood Clots
	High Blood Pressure
	Low Blood Pressure
	Lymph Edema
	Breathing Difficulty
	Sinus Problems
	Allergies
	Specify:
	Other/Elaborate:

	NERVOUS SYSTEM
	Herpes/Shingles
	Numbness/Tingling
	Chronic Pain
	Chronic Fatigue Syndrome
	Sleep Disorders
	Other/Elaborate:

	REPRODUCTIVE
	Women:
	Pregnant (Trimester):
	PMS
	Men/Women:
	Other/Elaborate:

	INFECTIOUS DISEASE
	Specify:

	SKIN
	Allergies
	Specify:
	Rashes
	Warts
	Other/Elaboarate:

	DIGESTIVE
	Constipation
	Gas/Bloating
	Diverticulitis
	Irritable Bowel Syndrome
	Other/Elaborate:

	OTHER
	Cancer
	Diabetes
	Eating Disorders
	Depression
	Drug/Alcohol Use
	Nicotine/Caffeine Use
	Other/Elaborate:

Client Signature: _____ Date:_____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name:_____ Relationship to Client: _____

(if signee is not client)

Financial Policy

(If Client is under 18, this form should be completed by parent or guardian)

Dear Client/Patient:

Welcome to Creative Wellness, Inc. The intent of this document is to inform you of Creative Wellness's Financial Policy. It is our objective that all our patients receive the best possible care and service. Therefore, your complete understanding of our financial policy as it relates to your financial obligation is essential. Please read this document thoroughly. Upon presenting to the office, you will be asked to sign this form stating that you have read, understood and will comply with the information contained within this document.

Payment is expected at the time of service.

Insurance- **Please check with your insurance company prior to making an appointment for their requirements for your policy!** This includes coverage, co-pays, deductibles, referral requirements, etc. Upon your arrival, please have your insurance card with you so we may make a copy of your card.

Referrals:

1. If you are being referred to Creative Wellness by a physician because of an auto accident or workers compensation, please be sure we have all the necessary documents. This includes referrals, letter from the insurance company with your claim information, and a signed financial responsibility statement before your first appointment. If your paperwork is not complete prior to your first appointment you will be asked to pay in full.
2. If you are receiving acupuncture, a referral is required from you doctor.
3. Some insurance companies may require a doctor's referral for chiropractic treatment. At times this may change your co-pay costs. Please call the customer service number on your insurance card to find out how many visits your policy covers.
4. Some insurance companies may require a doctor's referral for massage treatments. At times this may change your co-pay costs. Please call the customer service number on your insurance card to find out if you have massage coverage.
5. Always be sure your referral is signed by your primary physician. For acupuncture a referral can be from any M.D. or D.O.

Payments:

1. If you are a member of a health plan that Creative Wellness participates with, and your service is covered, we will submit your claim to your insurance company. Your co-payment is expected at the time services are rendered. Patients will be billed in full for any services that their health plan deems as "not a benefit" or a "non-covered service".
2. If Creative Wellness does not participate with your insurance carrier, payment in full will be required of you at the time services are rendered.
3. We will provide you with an insurance receipt if you would like to submit to your insurance company for reimbursement.
4. Medicare patients are responsible for services in full. We do not participate with Medicare.
5. Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. For minors, the parent who accompanies the minor for their first visit will be financially responsible for all charges incurred.
6. If a client is under the age of 18, this must be filled out by a parent or guardian.
7. Creative Wellness accepts cash, personal check, MasterCard, Visa, and ATM debit cards by the same carriers listed, as payments for services rendered.
8. A $25 fee will be assessed for any check returned for insufficient funds. At that time only cash, charge or money order will be accepted for payment.
9. Creative Wellness reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment or compliance with this policy. In the event you breach this agreement, you agree to pay all collection fees, including attorney's fees, incurred by us in enforcing the terms hereof, whether or not formal legal proceedings are commenced.

As a courtesy to our practitioners, we ask that you give a 24-hour cancellation notice. Failure to keep your scheduled appointment or same day cancellations will result in a charge of $25. After 3 late cancellations or missed appointments, the appointment will be charged in full. For parties of 3 or more, credit card numbers will be required for booking and any cancellation under 24-hours' notice will be charged in full.

Client Signature: _____ Date:_____

(Parent or guardian signature required if Client is under 18 Years of age)

Printed Name:_____ Relationship to Client: _____

(if signee is not client)