

Oasis Massage
Auto Accident / Personal Injury Claim

Contact & General Information

Client Name: _____
Date of Birth: _____ Occupation: _____
Address: _____
Phone: _____ Email: _____
How would you like to receive appointment confirmations? Email Text/SMS Both
 Check here if you do not want to be added to our mailing list.

Emergency contact: _____ Phone: _____

Referred by: _____ Phone: _____

Massage Information

Have you ever received professional massage/bodywork before? Yes No
If yes, how recently? _____

What types of massage/bodywork do you prefer? _____

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?
 Pain Management Injury Recovery Athletic Improvement Self-Care
 Relaxation Stress Relief Other: _____

How do you feel today? List & prioritize any symptoms (stress, pain, stiffness, numbness/tingling, swelling, etc.): _____

These symptoms interfere with sleep, exercise, work, childcare other: _____

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment? _____

Are you wearing: contacts? dentures? a hairpiece? other prosthetic?

Are you pregnant? Yes No *If yes, please complete Pregnancy Intake.*

Are you taking any medications? Yes No *If yes, please list them below.*

<i>Medication</i>	<i>Dosage</i>	<i>Side Effects, if any</i>

Do you currently have any of the following:

Blood clots Yes No Infections Yes No
Congestive heart failure Yes No Contagious diseases Yes No
Pitted edema Yes No

Please answer honestly, as massage may not be indicated for the above conditions.

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Health History (cont.)

Please indicate conditions that you have or have had in the past. Explain & describe any treatment received.

- | | | |
|----------------------------------|-------------------------------|---|
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Muscle or joint pain: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Muscle or joint stiffness: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Numbness or tingling: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Swelling: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Bruise easily: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Sensitive to touch/pressure: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | High/Low blood pressure: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Stroke or Heart attack: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Varicose veins: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Shortness of breath/Asthma: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Cancer: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Neurological (MS/Parkinson's/chronic pain): _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Epilepsy or Seizures: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Headaches or Migraines: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Dizziness or Ringing in the ears: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Digestive conditions (Crohn's/IBS): _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Gas, Bloating or Constipation: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Kidney disease/infection: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Arthritis (rheumatoid/osteoarthritis): _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Osteoporosis or Degenerative spine/disk: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Scoliosis: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Broken bones: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Allergies: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Diabetes: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Endocrine or Thyroid conditions: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Depression or Anxiety: _____ |
| <input type="checkbox"/> Current | <input type="checkbox"/> Past | Memory Loss, Confusion or Easily overwhelmed: _____ |

Additional Comments: _____

Consent for Treatment: If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork 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. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork 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 practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Cancellation & Late Policy: To avoid paying for missed appointments, a cancellation notice of 24 hours is required for all clients. Late cancellations & no-shows will be charged for 50% of the scheduled appointment. Clients who find someone to take their appointment will not be charged. Late arrivals will be accommodated, although session length may be shortened. Clients that arrive late will be charged for the full amount of the scheduled appointment, regardless of actual length of service. Clients that arrive late and opt to reschedule will be charged for the missed appointment.

Client Signature: _____ Date: _____

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Release of Records / Payment Agreement / Assignment of Benefits
Patient must sign prior to any medical treatment to be performed.

Patient: _____ Date: _____

Insurance Company: _____

Physician Referral: _____

Attorney (if applicable): _____

Release of Records: I hereby authorize PHM Services LLC dba Oasis Massage, my healthcare Provider/Facility, to release any and all medical information to the above named insurance carrier(s), or to my designated attorney, now or in the future, and/or to my physician(s), if necessary, for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to by my insurance carrier and to this provider of services.

Payment Agreement: All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above-mentioned facility/provider for charges not covered by my insurance policy or certificate. I further agree that in the event of non-payment, I will bear the expenses of collection and/or court costs, and reasonable legal fees, should this be required. I understand that if my commercial insurance has not paid the bill within 60 days of my visit(s), for my services received by my provider/facility, I am responsible, and I will then make whatever arrangements are necessary & available to me to pay all unpaid charges.

Assignment of Benefits: I hereby assigned to PHM Services LLC dba Oasis Massage, my Health Care Provider/Facility, all money to which I am entitled for medically related expenses received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that the facility/health care provider received by the insurance company beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits, and payment agreement and hereby acknowledge that I understand it. The payment agreement portion of this agreement may not be revoked in writing or otherwise.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

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Attorney Letter of Protection

Notice to Attorney: _____

Reference: Your Client/Our Patient: _____

Date of Accident: ____/____/____

Claim Number: _____

I/My Facility has rendered or is rendering medical services to the above-mentioned patient. Our Patient/Your Client has authorized, and directs, by his/her signature below, that you, as the attorney on this case, protect our outstanding bill for services arising out of this accident by withholding such sums from any settlement, judgment, verdict or other sources, that may become available to protect Me/My Facility's outstanding bills, by making direct payment for our bills to Me/My Facility, when, and should a settlement occur.

We understand that this is providing the settlement is adequate to cover all or an equal percentage, of our outstanding medical bills, and all other protected bills and legal fees. Patient/Client and I understand that, should not enough arise out of the settlement, or should you not be able to obtain a settlement for whatever reason, Patient/Client shall be solely responsible for all outstanding balances with Me/My Facility.

I/My Facility realizes that as long as litigation is in process for this accident, and as long as this Patient/Client remains with You/Your Firm, we will not initiate any collection proceedings for any unpaid balances until the case has been resolved. I understand to do so, would void this Letter of Protection. Patient hereby agrees that should for any reason, your services, or that of your firm, be suspended, I/My Facility may then begin collection proceedings immediately, unless patient obtains a letter of protection from another law firm immediately.

I/My Facility will cooperate with you in any manner possible, including making available to you, upon request, copies of any and all bills, and documentation reflecting treatment on this Patient/Client for which payment is expected out of this settlement.

I/My Facility, the undersigned Patient/Client, and Attorney, hereby agrees to observe all of the above terms and conditions.

Patient/Client: _____ Phone: _____

Patient Address: City: _____ State: _____ Zip: _____

Patient/Client Signature: _____ Date: ____/____/____

Attorney/Firm: _____

Attorney Signature: _____ Date: ____/____/____

Phone: _____ Fax: _____

Firm Address: City: _____ State: _____ Zip: _____

Facility: Oasis Massage Phone: 508-280-4242 Lic #: MT-1116-MM

Facility Address: 292B Route 28, West Dennis, MA, 02670

Therapist: Ashley Bilodeau Lic #: 13704 Pallas Hutchison Lic #: 1998

Therapist Signature: _____ Date: ____/____/____

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Personal Injury / Auto Accident / Slip & Fall Case

Do you have No – Fault PIP benefits? Yes No
If yes, are there benefits left? Yes No

Do you have a deductible? Yes No
Amount: \$ _____ Has it been met? Yes No
If not, how much deductible is left to be met? \$ _____

What percentage does your insurance cover? _____%

What are the policy limits? \$ _____

Do you have MED-PAY on your policy? Yes No (picks up the .20%)
Do you have U/M (Uninsured Motorist Protection)? Yes No
Were you cited in the accident? Yes No Not Sure

Were you struck from: Behind Front R Side L Side Other: _____

If other, please explain: _____

Did you feel pain immediately after the accident?

If yes, where? _____

If no, when did you first start feeling pain? _____

Since the injury, symptoms have been: Improving Getting Worse Staying the Same
 Changing (please explain): _____

Were you the: Driver Passenger Pedestrian Other: _____

Information on Driver of Vehicle At Fault:

Name: _____ Phone: _____

City: _____ State: _____ Zip: _____

Insurance Carrier: _____ Policy #: _____

Have you obtained an attorney for this case? Yes No

Attorney or Law Firm: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____