Oasis Massage
Major Medical Insurance 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: _____
Were you referred by a doctor or will you be seeking reimbursement from an insurance company?
☐ Yes ☐ No If yes, a physician's prescription will be required.

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.*

Medication	*Dosage*	*Side Effects, if any*

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.

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