Whispering Falls Massage Therapy

Date: ____________________ Name: ____

Address: ____ City: _______________________ State: ______ Zip: ___________

Home Phone: ____________________________ Work: ______________________________ Cell: ___________________________

☐ I agree to receive text messages to the cell phone above reminding me about my upcoming appointments with Whispering Falls Massage therapy. I understand that SMS reminders are optional and that message and data rates may apply.

Date of Birth: _________________ Email Address: ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: ____ Phone: __________________________________

Were you injured? ☐ Yes ☐ No If yes, Date of Injury:________________________ ☐ Work Injury ☐ Auto Accident

Employer: ____

Address: ____ City: _____________________ State: ______ Zip: _________

Whom may we thank for referring you to our office: ____

Health History

☐ Bone or Joint Disease ☐ Constipation/Diverticulitis ☐ Sinus Problems

☐ Tendonitis/ Bursitis/ Arthritis ☐ Cancer/Tumors (Past/Present) ☐ Sprains/Strains

☐ Irritable Bowel Syndrome ☐ Neck, Shoulder, Arm Pain ☐ Herpes/Shingles

☐ Headaches/Head Injuries ☐ Numbness/Tingling ☐ Spasms/Cramps

☐ Chronic Pain ☐ Jaw Pain/TMJ ☐ Fatigue

☐ Heart Condition ☐ Sleep Disorder ☐ Blood Clots

☐ High/Low Blood Pressure ☐ Breathing Difficulty ☐ Lymphedema

☐ Depression ☐ Disease Name(s) _________________ ☐ Allergies _____________________________

☐ Pregnant? Stage: __________________ ☐ Medications: ____

IMPORTANT

Please Read, Initial, Sign and Date

______There will be a $30.00 fee for appointments cancelled with less than a 24 hour notice and a $60.00 fee for no-shows. A one-hour full body massage is based upon a 50-minute professional hour. This allows you 5 minutes to disrobe and 5 minutes to re-clothe yourself. In consideration of others, we ask that you please be on time for your appointment.

Insurance Clients

_____ As a courtesy we will be more than happy to check your insurance for eligibility and benefits. This is NOT a guarantee of coverage. You should be aware of your yearly maximum, frequencies, deductibles, waiting periods and limitations. We expect your ESTIMATED portion at time of service (unless prior arrangements have been made.) You are responsible for any portion not paid by your insurance carrier 90-days from date of service. We recommend that you reach out to your insurance company as well for confirmation of benefits.

Payment at Time of Service

_____ Co-pays, co-insurance and deductibles are due at time of service. A $10 service fee will be charged for copays, co-insurance or deductibles not paid at time of service

*Information about the ESTIMATED charges of your health services is available upon request. Please do not hesitate to ask for information.

Thank you for your consideration.

Signature: ____ **Date:** ____________________________