WhisperingFalls
MASSAGE THERAPY

Patient Consent for use and Disclosure of Protected Health Information

I hereby give my consent for Whispering Falls, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Whispering Falls, Inc. describes such uses and disclosures more completely.)

I have the right to review the *Notice of HIPPA Privacy and Novel Coronavirus Notice* prior to signing this consent. Whispering Falls, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whispering Falls, Inc. Attn: Privacy Officer, 13701 E. Sprague Ave. Spokane Valley WA 99216.

With this consent, Whispering Falls, Inc. may call my home or other alternative location and leave a voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Whispering Falls, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Whispering Falls, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Whispering Fall, Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Whispering Falls, Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Whispering Falls, Inc. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name **Date**

**Names of People that you would like to have full access to your PHI (such as billing information, appointments, and health records).

_____ _____

Name of Person & Relationship to insured Name of Person & Relationship to insured

_____ _____

Name of Person &Relationship to insured Name of Person & Relationship to insured

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 $70.00 fee (per massage hour) for appointments cancelled, with less than a 24-hour notice and 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:** _____