

Transcend Bodywork llc

New Client Intake:

Name: _____ Date: _____ D.O.B.: _____
Address: _____ Apt.: _____ Zip: _____
Phone #'s Home: _____ Work: _____ Cell: _____
Email: _____ Emergency contact: _____
Occupation: _____ Referred By: _____
Are you being treated for an auto accident? _____ Date of Accident: _____
Insurance Co.: _____ Address: _____
Claim# _____ Ins. Adjuster: _____ Phone# _____
Attorney: _____ Phone# _____

Please complete both pages of this form.

-Are you currently under a physicians care (MD., D.C., ND., DO.)? With whom? For what?

-Are you working with any other therapy providers (counseling, physical therapy, energy work, acupuncture, etc.)?

-Please list any surgeries, major illnesses or injuries: (List all that come to mind while thinking about your current health status.)

-What medications (prescription or over the counter), vitamins or herbal supplements do you take? What are they for? Do you have any side effects?

Please check conditions you currently experience or have had trouble with in the past:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Nicotine Use	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Easy Bruising
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Headaches or Migraines	<input type="checkbox"/> Numbness
<input type="checkbox"/> Athletes Foot	<input type="checkbox"/> Allergies	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Asthma	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Skin Disorders
<input type="checkbox"/> Abuse	<input type="checkbox"/> V.D.	<input type="checkbox"/> Constipation
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes
<input type="checkbox"/> Stroke	<input type="checkbox"/> Mental Health Issues	<input type="checkbox"/> Cold or Influenza
<input type="checkbox"/> Communicable Disease	<input type="checkbox"/> Dislocations	<input type="checkbox"/> Sprains or Strains
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Hearing Impairment

-What are the primary sources of stress in your life?

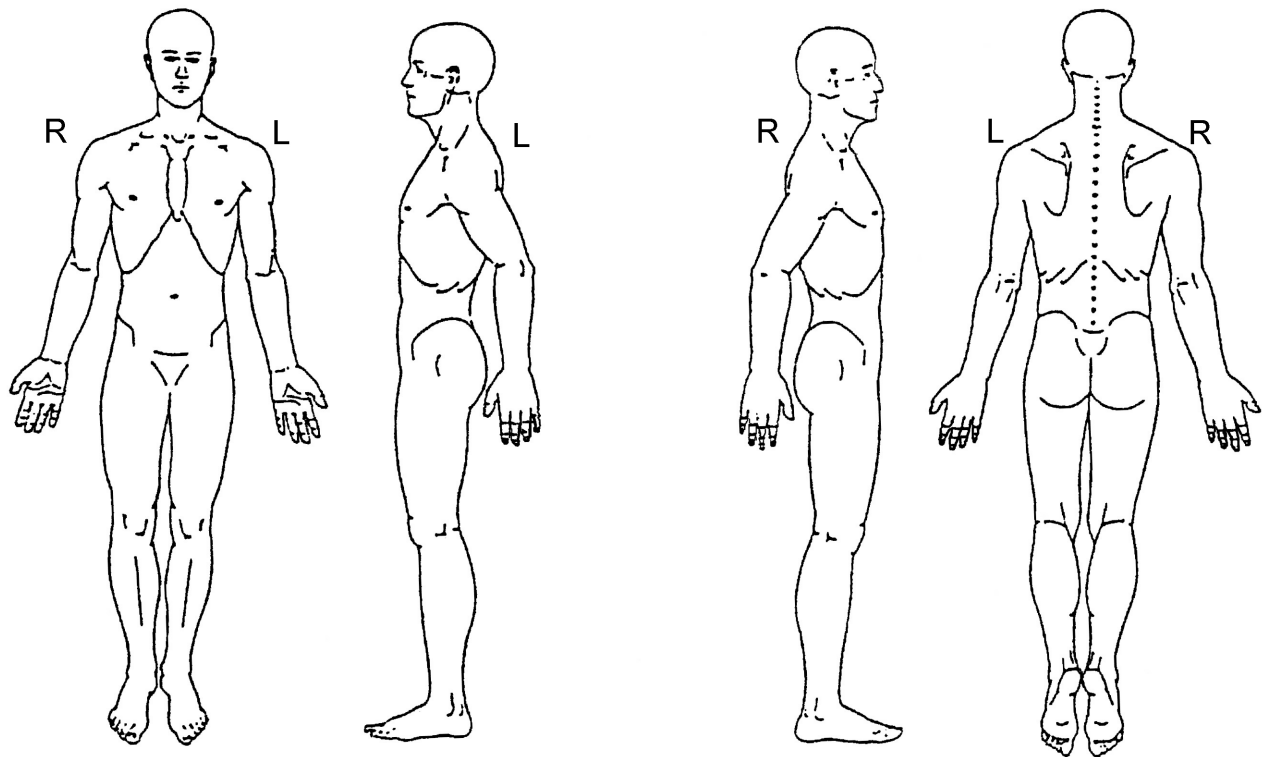
-Where in your body do you most notice the effects of stress? What symptoms do you notice?

-What do you do for exercise? If none, what physical activities do you regularly participate in? (hobbies, etc.)

-What do you do to relax?

-How are you feeling today? (Comment on emotional and physical state please.)

-Please indicate areas of discomfort or desired work by drawing on the diagram below:



I understand that the purpose of this massage is to promote and maintain good health and physical condition, and that Licensed Massage Therapists may not diagnose injury or disease. Massage should not take the place of a Doctors care when care is necessary. Either you the client or the therapist may terminate the relationship should either be experiencing discomfort inappropriate to the situation, including but not limited to physical pain or sexual impropriety. I agree to abide by all office policies of Transcend Bodywork LLC and Aaron Gustafson LMT including the right to refuse service to anyone.

Client Signature _____

Date _____

Transcend Bodywork llc
Aaron Gustafson LMT CAMT
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Portland, OR 97202
Phone 503-407-6046 Fax 503-233-3660
Email Aaron@TranscendBodywork.com

9-10-2011

Fee Schedule for Billed Services

Prices are per unit, one unit = 15 minutes. One hour = 4 units. Billed Rate = \$160.00 per hour.

CPT Code		Fee
97124	Massage Therapy	\$40.00
97250	Myofascial Release/Soft tissue mobilization	\$40.00
97140	Manual Therapy	\$40.00
97010	Hot/Cold Pack Hydrotherapy	\$15.00

Point of Service Discount: payment at time of service eligible for 50% discount (=\$80.00 per hour)
Pre-payments for service packages of three sessions are eligible for an additional \$5 per session discount. Yes, it really does take twice the time to dance with your insurance company !

Hydrotherapy may be billed simultaneously with other therapies. My time presenting seminars and workshops is not eligible for the point of service discount- they are billed at \$160 per hour.

Payment due within 30 days of service if billing is requested. Late payments are subject to 5% monthly late fee. Clients are fully responsible for any amounts left unpaid by Insurance. We do not bill Medical Insurance, only Auto Insurance for accident treatment. With a Doctor's referral, we can provide an invoice to help you seek reimbursement from your Medical Insurance, FSA or HSA. Please inquire.

Missed or canceled appointments with less than 24 hours notice still incur full session charges, due before any subsequent sessions.

Cancelled or Insufficient funds checks subject to \$30.00 fee + any bank fees.

Fees and policies are subject to change without notice.

Print Name: _____

I have read and agree to the above fees and policies of Transcend Bodywork LLC and Aaron Gustafson LMT

Method of payment: Bill me _____, Bill insurance(Auto Accident)_____, Cash or Check_____,

Or Credit Card* _____ Visa____ MC____ Disc____ Card # _____ Expires _____
Card ID# _____ (the last three digits found on the signature bar) Billing Zip Code: _____

Signed _____ Date _____

*Credit card payments add 3% convenience fee.