# Transcend Bodywork llc

**2700 SE 26th Ave, Ste. C, Portland, OR 97202 p:503-407-6046**

Name:_____Pronouns: _____Birthdate:_____
Legal Name: (If different, for insurance billing purposes)_____
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?

-Describe the work you do with any other therapy providers (counseling, physical therapy, energy work, acupuncture, other forms of massage, 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:**

___ Heart Disease
___ Indigestion
___ Osteoarthritis
___ Broken Bones
___ Athletes Foot
___ Asthma
___ Abuse
___ Incontinence
___ HIV or AIDS
___ Stroke
___ Communicable Disease
___ Eating Disorder
___ Nicotine Use
___ Diabetes
___ Dizziness
___ Headaches
___ Migraines
___ Varicose Veins
___ Constipation
___ Fatigue
___ Cancer
___ Mental Health Issues
___ Dislocations
___ Allergies
___ Substance abuse
___ High Blood Pressure
___ Easy Bruising
___ Numbness
___ Low Blood Pressure
___ Skin Disorders
___ Hearing Impairment
___ Joint Swelling
___ Hypermobility
___ Cold or Influenza
___ Sprains or Strains
___ Visual Impairment

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

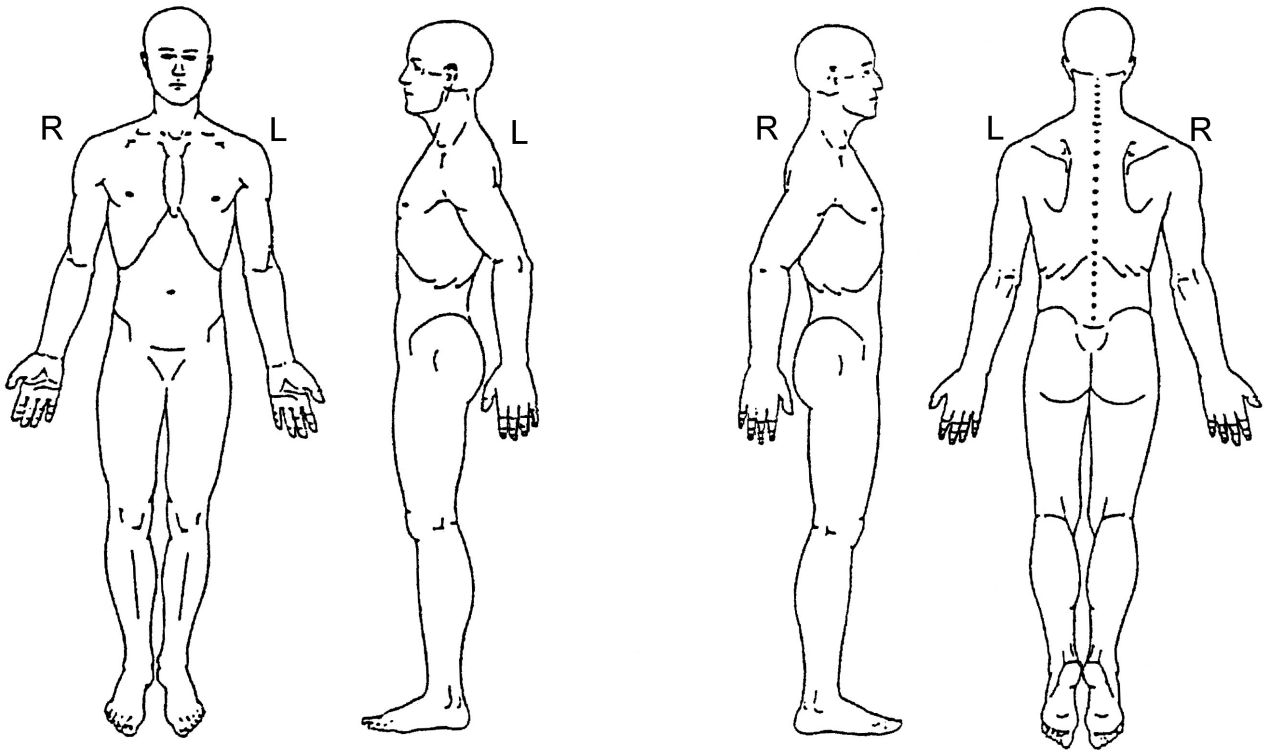
-Where in your body do you most notice the effects of stress? What symptoms do you notice?

-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 II

2700 SE 26th Avenue Suite C

Portland, OR 97202

Phone 503-407-6046 Fax 971-255-5815

Email Aaron@TranscendBodywork.com


6-15-2019

**Fee Schedule for Billed Services**

Prices are per unit, one unit = 15 minutes. One hour = 4 units. Billed Rates = $132 to $180 per hour.

CPT CODES:

| | | |
|---|---|---|
| 97124 | Massage Therapy- Therapeutic: | $45.00 (Used for Physician directed care.) |
| 97140 | Manual Therapy- Myofascial: | $45.00 (Used for Physician directed care.) |
| 8E0KX1Z | Relaxation Massage: | $33.00 (Used for self directed care only) |

**Time of Service Discount: payment at time of service eligible for 20% discount (= as low as $105/hr for 8E0KX1Z). Pre-paid promotional wellness packages of 3 sessions available at an additional $30.00 discount.** Unused promotional wellness package sessions expire after 90 days from date of first package session.

Not all insurance plans cover massage – please check with your plan before requesting medical insurance billing. If your plan covers massage, please email or text pictures of the front and back of your ID card along with your birth date to aaron@transcendbodywork.com or 503-407-6046 before your first session and I'll verify your benefits/co-pays. Auto Insurance for auto injuries happily accepted.

Payment due within 30 days of billed service. Late payments are subject to 5% monthly late fee. Clients are fully responsible for any amounts left unpaid by Insurance. FSA & HAS payments accepted as long as they've provided you with a debit/credit card for your account, or we can provide an invoice to help you seek reimbursement from your FSA or HSA.

**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 $35.00 fee + any bank fees.

Fees and policies subject to change without notice.

Print Name:_____

I have read and agree to be responsible for the described fees, and all office policies of Transcend Bodywork LLC and Aaron Gustafson LMT.

Method of payment: Bill me _____, Bill insurance(Auto_____, Medical_____,) Cash or Check_____,

Credit Card*____, Valid card on file required after your first cancellation with less than 24 hours notice.

Signed_____Date_____