

Advanced Neuromuscular Therapeutics  
Medical Massage Therapy Clinic

**CONFIDENTIAL CASE HISTORY**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_  
AGE: \_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
PHONE: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
SS#: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_ Email: \_\_\_\_\_  
Have you had a professional massage before? \_\_\_\_\_ What type of pressure do you prefer? \_\_\_\_\_

**CURRENT HEALTH**

Present Symptoms (your major complaint): \_\_\_\_\_

Date of Injury: \_\_\_\_\_ When did symptoms start? \_\_\_\_\_

In a few short words, describe the accident: \_\_\_\_\_

Were you wearing a seatbelt? \_\_\_\_\_ Did the airbag release? \_\_\_\_\_ Standard or automatic? \_\_\_\_\_

What activities/in-activities aggravate the symptoms? \_\_\_\_\_

Current Therapies? (PT, DC, etc...) Yes \_\_\_\_\_ No \_\_\_\_\_ Where? \_\_\_\_\_

Frequency? \_\_\_\_\_

Minor complaints (other areas of pain or concern RELATED to the injury): \_\_\_\_\_

Does this affect your sleep pattern? Yes \_\_\_\_\_ No \_\_\_\_\_ Is it hard to go to sleep? \_\_\_\_\_

Do you have interrupted sleep? \_\_\_\_\_ Is it hard to get comfortable? \_\_\_\_\_

Describe your most comfortable sleeping position: \_\_\_\_\_

Do you feel your pillow is supportive? \_\_\_\_\_ Your mattress? \_\_\_\_\_

Date of X-rays \_\_\_\_\_ Date of MRI \_\_\_\_\_

WOMEN only: Are you pregnant? \_\_\_\_\_ If yes, what month? \_\_\_\_\_ Pregnancy # \_\_\_\_\_

Are you taking any of the following? Circle all that apply:

Anti-inflammatories      Muscle Relaxers      Pain med's      Sleeping pills      Aspirins  
Anti-depressants      Insulin      Any Injections? \_\_\_\_\_

Prior to this visit, have you received treatment for this injury? (describe) \_\_\_\_\_

**CURRENT SELF CARE**

Have you or are you using/doing the following?:

Ice Packs? \_\_\_\_\_ Heating pad? \_\_\_\_\_ Epsom soaks or compresses? \_\_\_\_\_ Stretching? \_\_\_\_\_ Ibuprophen \_\_\_\_\_

If yes, describe \_\_\_\_\_

On a scale from 1-10 (10 being high) how high is your stress level? \_\_\_\_\_

(work, family, relationships, car, money....etc)

How long has your stress been like this? \_\_\_\_\_

Weekly exercise Activities: \_\_\_\_\_

Weekly habits:

Alcohol \_\_\_\_\_ average per week                  Coffee/Tea/Caffeine \_\_\_\_\_ average drinks per week

Tobacco \_\_\_\_\_ average per week                  Water intake \_\_\_\_\_ average ounces per day

**EXPECTATIONS AND GOALS**

Briefly describe: \_\_\_\_\_

Have you ever:

	Yes	No	Briefly describe
Had any operations	_____	_____	_____
Broken bones?	_____	_____	_____
Been in a previous accident?	_____	_____	_____
Had Whiplash	_____	_____	_____

Other:

Do you wear orthotics? \_\_\_\_\_ Which is your dominant hand? \_\_\_\_\_

Which pocket do you carry your wallet in? \_\_\_\_\_ Do you sit on your wallet? \_\_\_\_\_

Which shoulder do you carry your purse on? \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_ Contact: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Attorney Firm and Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Name of insured: \_\_\_\_\_



## FINANCIAL RESPONSIBILITY AGREEMENT INSURANCE

Please read this agreement carefully. If you need clarification with any issue, we encourage you to ask.

As health care providers, it is important for us to clarify our standard procedures for billing insurance companies and patients at the beginning of treatment, so there is no confusion or misunderstanding. If you do not understand the following, a 5-10 minute meeting must be scheduled by your third treatment to explain these billing procedures and patient responsibilities in detail. This meeting is for our protection.

I agree to give 24-hrs notice of cancellation of my appointment. I understand that my therapist will schedule a minimum of one hour for each appointment. Unfilled hours will be billed to me at the rate \$30.00 per hour.

I will keep my therapist informed of any changes in my health as they occur, including medicines, therapies, etc.

Self-care is assigned. Written instructions will be provided as to enhance your recovery. Please make every effort to participate in assigned stretching, soaks, and the use of heat or ice. Postural consideration may also be addressed.

**I understand that my insurance is an agreement between the insurance company and myself.**

I, \_\_\_\_\_, take **full responsibility** for all bills incurred for treatment.

We will assist in billing your insurance carrier; however, the responsibility of payment for services rests with the patient or guarantor. This means that, if your insurance company does not pay within 60 days of date of service, or your deductible is not met, you are required to pay immediately-no exceptions.

### **Patient Information**

All charges are determined by the therapeutic procedures performed and the amount of time spent by the therapist. Be aware that your treatment cost may vary because your insurance company determines the responsible and customary charges based on the therapeutic procedures performed and the amount of time spent. The prescription letter of referral written by your prescription letter of referral written by your prescription determines what body areas and therapeutic procedures we perform.

**For group Insurance patients**, our standard procedures and your responsibilities are the following:

1. Group insurance companies do not guarantee payment when benefit information is requested; therefore, it is your responsibility to pay for all bills that you incur if your insurance does not pay.
2. If your insurance does not cover your treatment, 100%, the co-pay is due at time of each treatment.
3. If your deductible is not met, immediate payment from you is expected.
4. All payment arrangements need to be discussed with the practice manager before treatment is received.

In the event that fees are not paid as requested, a collection agency and possible legal action may follow. If so, I will be responsible for all reasonable costs associated with the collection of such fees, including attorney and court costs.

I authorize payments to be made on my behalf to this provider for any services furnished.

I authorize any holder of information about me to release such information needed to determine these benefits or to assist in the collection of payment for services.

I authorize Advanced Neuromuscular Therapeutics/Carolyn Durham, Inc at any time I have an outstanding bill to be able to contact the insurance company for an exact dollar amount of benefits that I have left.

A copy of this agreement will be as valid as the original

**I have read and I do understand the financial agreement thoroughly.**

Signature \_\_\_\_\_ Date: \_\_\_\_\_