



ALIGNED MEDICAL MASSAGE

YOUR EXPERTS IN PAIN MANAGEMENT

Billing Information

Please enter your information.

First Name:

Last Name:

Date of Birth:

Gender:

☐ Female ☐ Male

Sex Assigned at Birth

Marital Status:

☐ Single ☐ Married
☐ Domestic Partner
☐ Separated ☐ Divorced
☐ Widowed

Email:

Street Address:

Apt./Unit #:

City:

State:

Zip Code:

Primary Contact Phone Number

Preferred Language:

Emergency Contact Name & Relation

Emergency Contact Phone #

Is an interpreter needed for your appointment?

☐ Yes ☐ No

How will you be Paying for your appointment?

☐ Pacific Source/Medicaid Insured ☐ Self Pay

Please enter your PRIMARY insurance information: *Attention Patients: Our clinic only accepts Pacific Source/Medicaid as a primary insurance. Unfortunately, we are unable to accept patients who have Pacific Source as their secondary insurance at this time. If you have scheduled an appointment and do not have Pacific Source as your primary insurance, please contact our office immediately. Thank you for your understanding

Primary Insurance Name

Member ID

Relationship to Policy Holder

Do you have a referral from your Dr. or chiropractor?

☐ Yes ☐ No

Please Attach: -Picture of you ID - Picture of primary insurance card (Front and back) - Picture of your secondary insurance card (Front and back) - Picture of your referral (From your primary care provider or chiropractor)

Who is your primary insurance?

How did you hear about us? (Please check all that apply)

How did you learn about this office?

Referring Provider

Current pain:

Please Check the areas where you are experiencing pain or discomfort. Please Note: If you do not have a referral from a doctor, PacificSource only covers pain codes related to the neck, mid-back, and low back. Be sure to specify your pain locations clearly to ensure proper coverage and accurate documentation of your condition.

☐ Head / neck

☐ Mid back / Shoulders

☐ Low back / Hips

☐ Legs / Feet

☐ Arms / Hands

Describe your symptoms and duration. What helps or worsens them?

If you have pain, is it:

☐ Dull

☐ Aching

☐ Throbbing

☐ Unbearable

☐ Electric

☐ Sharp

☐ Numbness

☐ Tingling

☐ Headaches

☐ Discomfort

On a 1-10 scale how severe is your pain: (1=Very little pain. 10= Worst pain ever)

Today

Best day

Worst day

What goal(s) do you have for your therapy session?

Health History

How would you rate your physical health?

☐ Excellent

☐ Good

☐ Fair

☐ Poor

Have you had a professional massage before? If yes, What Style or Pressure is Preferred?

What Style or Pressure is Preferred?

Do you have difficulty lying flat on your back, side or stomach? If yes, please explain.

If yes, please explain:

Do you need access to our wheel chair ramp for you appointments?

☐ Yes

☐ No

Do you have any allergies to creams, oils, lotions, or sensitive skin? If yes, please explain. Do you have any allergies to anything else? If yes please Explain.

If yes, please explain:

Do you sit for long periods or perform repetitive movements? If yes, please explain.

If yes, please explain:

Do you experience significant stress in work, home or other aspect of your life? if yes, Please explain how this has affected your health.

Do you have any of the following conditions? (Check all that apply)

☐ Skin Issues: Skin Infection, Open Sores/Wounds, Easy Bruising/Bleeding

☐ Circulatory Issues: Blood Clots, Swollen Glands, Osteoporosis/Osteopenia

☐ Sensory Issues: Decreased Sensation, Sensitivity to Heat/Cold

☐ Autoimmune Issues: Autoimmune Disorder, Fibromyalgia

☐ Cardiovascular Issues: Heart Condition, High Blood Pressure, Dizziness/Lightheaded

☐ Other Conditions: Cold/Flu, Current Fever, Diabetes, Back/Neck problems, Carpal Tunnel Syndrome, Depression/Anxiety, Arthritis/Joint Pain, Cancer, Circulatory Disorder, Epilepsy/Seizures

☐ Pregnancy (list number of months below)

Pregnancy (months) / Other

Have you had any recent surgeries or procedures?

☐ Yes

☐ No

If yes, please describe:

Have you had any recent accidents, injuries or broken bones?

☐ Yes

☐ No

If yes, please describe:

Are you under medical care? If yes, please explain.

Are you currently taking any medications? Please list: Medication Name, Dosage, Frequency, Reason for taking" to "List any current medications and their purpose

Do you have chronic pain?

☐ Yes

☐ No

Please Explain (including location and change in mobility):

Please list any other conditions we should know about:

HIPPA Compliance Agreement

HIPAA Compliance and Privacy Practices Agreement

Aligned Medical Massage is committed to the confidentiality, integrity, and security of patient Protected Health Information (PHI) in compliance with the Health Insurance Portability and Accountability Act (HIPAA) and relevant Oregon state laws. This agreement outlines our practices and the rights of our patients concerning their PHI.

Notice of Privacy Practices Acknowledgment I acknowledge the Notice of Privacy Practices from Aligned Medical Massage, which outlines how my PHI may be used and disclosed and my rights regarding my PHI.

Permitted Uses and Disclosures Aligned Medical Massage may share my PHI with healthcare providers and for billing with insurance companies, including PacificSource, to ensure coordinated care and claim management. This includes necessary disclosures for treatment, payment, and healthcare operations, adhering to the minimum necessary standard.

Patient Rights I understand my rights regarding PHI include, but are not limited to:

- Requesting restrictions on certain uses and disclosures of PHI.
- Receiving confidential communications.
- Inspecting and copying my health records.
- Requesting amendments to my health information.
- Receiving an accounting of disclosures.
- Filing a complaint if I believe my privacy rights have been violated.

Breach Notification I will be notified in the event of a breach of unsecured PHI as required by HIPAA.

Electronic Health Records (EHR) Aligned Medical Massage uses EHRs securely, ensuring the confidentiality and security of my PHI.

Authorization for Non-Standard Disclosures Uses or disclosures not covered by this agreement or the Notice of

Privacy Practices require my written authorization.

Minor Patients Aligned Medical Massage respects the privacy of minor patients. Parents or legal guardians have access to their minor child's PHI, except in cases where minors can legally consent to their own treatment under Oregon state laws. The clinic adheres to state guidelines to protect minor patients' rights and confidentiality.

Language Assistance Services Aligned Medical Massage provides language assistance services at no cost to PacificSource members with limited English proficiency or those who are deaf/Deaf or hard of hearing, ensuring compliance with PacificSource's Language Access Plan. This includes oral interpretation and written translation of vital documents to facilitate meaningful access to health services.

Text Messaging Risk Acknowledgment I understand that standard text messaging is not secure under HIPAA regulations. Messages may be visible to others if my device is unattended or compromised. I acknowledge that text communications with Aligned Medical Massage may include limited PHI and accept the associated privacy risks.

Amendments to the Agreement Aligned Medical Massage reserves the right to change this agreement and will provide a revised notice as required by law.

Patient Care and Services Agreement

Patient Care and Services Agreement

Introduction: This Patient Agreement outlines the terms under which Aligned Medical Massage provides services to its patients, ensuring a clear understanding and agreement between the patient and the clinic on consent for treatment, financial responsibilities, insurance billing practices, privacy practices, and more.

Consent for Treatment: I hereby consent to receive massage, manual therapy, and acupuncture services from licensed professionals at Aligned Medical Massage. I understand these services are designed to aid in relaxation, injury recovery, and pain relief but are not substitutes for medical treatment.

Additionally, I voluntarily consent to receive acupuncture treatment at Aligned Medical Massage. I understand that acupuncture involves the insertion of fine needles into specific points on the body to promote healing and balance.

Potential Benefits:

- Pain relief and improved circulation
- Reduction in stress, anxiety, and tension
- Support for overall well-being

Potential Risks: While acupuncture and massage therapy are generally safe, possible risks include:

- Temporary soreness, bruising, or minor bleeding at needle or massage sites
- Dizziness, lightheadedness, or fatigue
- Aggravation of symptoms before improvement
- Rare risk of infection (sterile, single-use needles are always used)

Acknowledgment & Consent: I understand that acupuncture and massage therapy are not replacements for medical care and that I should inform my provider of any medical conditions, including pregnancy, bleeding disorders, pacemakers, or medications. I acknowledge that I have read and understand the risks and benefits of these treatments. I agree to seek medical attention if I experience any severe reactions.

Financial Responsibility and Insurance Billing: I am financially responsible for all services received. Aligned Medical Massage will bill my health insurance, including OHP/PacificSource as a courtesy, provided:

- Accurate insurance information is provided to avoid claim denial.
- I am responsible for deductibles, co-payments/co-insurances, and any non-covered services.
- Payment for non-covered services and any remaining balance after insurance processing is due upon receipt of the first statement.

HIPAA Compliance and Privacy Practices: I acknowledge having received and understood the HIPAA Compliance and Privacy Practices of Aligned Medical Massage & Acupuncture, which outlines the use and protection of my protected health

information (PHI).

Appointment Commitment Policy: Delivering timely and effective care is foundational to our practice, requiring that appointments are either honored or rescheduled with a minimum of 24 hours' notice. We hereby inform our patients that a failure to provide adequate notice for three appointments within a single calendar year will result in our refusal to schedule future appointments. Furthermore, following the second missed appointment without appropriate notice, we will enforce a temporary suspension of services for a period of three months. We sincerely appreciate your cooperation and understanding in helping us maintain an orderly and fair appointment system for our entire patient community.

Minors Policy: Services to minors are provided only with the consent of a parent or guardian. The parent or guardian must agree to the terms of this agreement on behalf of the minor.

Personal Property: I acknowledge that Aligned Medical Massage & Acupuncture is not responsible for the loss or damage of personal belongings while I am on the premises.

Late Arrival Policy: If I arrive late, my session will end at the scheduled time, and I am responsible for full payment, as the time was reserved for my treatment.

Changes to Services or Prices: I understand that Aligned Medical Massage & Acupuncture reserves the right to modify services offered and pricing at any time.

Acknowledgment and Signature: I have read, understood, and agree to the terms outlined in this Patient Agreement, including the additional policies on minors, personal property, late arrivals, and changes to services or prices.

Waitlist Notification Opt-In:

Receive Automated Texts When Appointments Open Up (Optional)

This consent is completely voluntary and is NOT required to receive services from Aligned Medical Massage.

Our office can send you automated text messages when appointment times become available due to cancellations. Your preferences for days, times, and therapists will be set up with our staff during your visit.

would You Like to Receive Automated Texts When Appointments Open Up

☐ YES, I would like to join the automated waitlist notification system

☐ NO, I do not wish to receive automated waitlist notifications

Authorization for Appointment Management I hereby authorize the individual named below to manage my appointments on my behalf. This authorization includes scheduling, changing, or canceling appointments. It does not grant access to my medical records or allow for decisions regarding my treatment. I understand that it is my responsibility to ensure that the named individual is aware of this authorization and acts in accordance with my wishes.

Signature

Date

Acknowledgment and Agreement: By signing below, I confirm that I have read, understood, and agreed to the terms, policies, and disclosures outlined in this packet, including the Massage Therapy Intake Form, Billing Information, Health History, HIPAA Compliance Agreement, and Patient Care and Services Agreement.

Signature

Date