



**MVA MESSAGE PATIENT INFORMATION**

**Patient** Claim: \_\_\_\_\_ Date: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Gender:  Male  Female  
 Marital Status:  Single  Married  Other Spouse's Name: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Employed  Full-time Student  Part-time Student

**Referring Physician**  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Insured**  
 Patient Relationship to Insured:  Self  Spouse  Child  Other \_\_\_\_\_  
 Insured Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Insured's Date of Birth: \_\_\_\_\_ Gender:  Male  Female Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Claim Representative: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Nature of Accident**  
 Date and time of accident: Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 State in which accident occurred: \_\_\_\_\_  
 Were you:  Driver  Passenger  Front Seat  Back Seat  
 Number of people in your vehicle? \_\_\_\_\_ Were you wearing seat belts?  Yes  No  
 What direction were you headed?  North  East  South  West  
 On (name of street) \_\_\_\_\_  
 What direction was other vehicle headed?  North  East  South  West  
 On (name of street) \_\_\_\_\_  
 Were you struck from:  Behind  Front  Left side  Right side  
 Approximate speed of your car \_\_\_\_\_ mph Other car \_\_\_\_\_ mph  
 Were you knocked unconscious?  Yes  No  
 Were police notified?  Yes  No  
 In your own words, please describe accident: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



MVA MASSAGE MEDICAL HISTORY

Patient: \_\_\_\_\_ Claim: \_\_\_\_\_

Did you have any physical complaints BEFORE THE ACCIDENT? [ ] Yes [ ] No If yes, please describe in detail: \_\_\_\_\_

Please describe how you felt:

DURING the accident: \_\_\_\_\_

IMMEDIATELY AFTER the accident: \_\_\_\_\_

LATER THAT DAY: \_\_\_\_\_

THE NEXT DAY: \_\_\_\_\_

What are your PRESENT complaints and symptoms? \_\_\_\_\_

Did you feel pain immediately? [ ] Yes [ ] No Where? \_\_\_\_\_

If NO, when did you first start feeling pain? \_\_\_\_\_

Since the accident, are your symptoms: [ ] Getting worse [ ] Improving [ ] Staying the same [ ] Changing (explain) \_\_\_\_\_

Do you have any congenital (from birth) factors which relate to this problem? [ ] Yes [ ] No If yes, please describe: \_\_\_\_\_

Do you have any previous illnesses which relate to this case? [ ] Yes [ ] No If yes, please describe: \_\_\_\_\_

Where were you taken after the accident? \_\_\_\_\_

What type of treatment did you receive? \_\_\_\_\_

Do you notice any activity restrictions as a result of this injury? [ ] Yes [ ] No If yes, please describe in detail: \_\_\_\_\_

Have you lost time from work as a result of this accident? [ ] Yes [ ] No If yes, please complete the following:

Last day worked: \_\_\_\_\_ Occupation: \_\_\_\_\_

[ ] Been unable to work since accident

Other pertinent information: \_\_\_\_\_

I understand that massage therapy is provided for the purpose of, but not limited to the following reasons: fulfilling a prescription of a treating physician, for a medically necessary condition; for relaxation purposes to relieve tension, stress, muscle pain and spasms, or for increasing circulation, energy flow, or range of motion.

I understand that massage therapists do not diagnose, prescribe, or offer medical advice for any illnesses, diseases, or conditions. Massage therapists do not do spinal manipulations, nor do they act in the manner of, or take the place of a licensed physical therapist. I understand that massage therapy is no substitute for medical examinations by a physician for a medical condition. It is understood that I must see my physician for any, and all, physical ailments that I may experience. I have hereby stated any, and all, existing physical conditions that I am aware of, so that the massage therapist may act responsibly when providing me with massage therapy services.

\_\_\_\_\_  
Patient or Authorized Person's Signature Date



**RoseSprings Medical**  
 5215 NE Elam Young Parkway, Suite A  
 Hillsboro, Oregon 97124-6498  
 Phone 503-693-9101  
 Fax 503-693-9123  
 EIN 27-0256414

**RELEASE OF RECORDS  
 PAYMENT AGREEMENT  
 ASSIGNMENT OF BENEFITS**

*Patient to sign prior to any medical treatment to be performed.*

Patient: \_\_\_\_\_ Claim: \_\_\_\_\_

This form may be submitted by fax or copies and be as valid as if it were the original. My attorney, in writing, to RoseSprings Medical and/or my insurance company may in the future, revoke the assignment portion. Revocation of assignment will in no way release me from the payment agreement portion. The payment agreement portion of this instrument may not be revoked in writing or otherwise.

**Release of records:** I hereby authorize RoseSprings Medical to release medical or any other necessary information or records, pertaining to services received by me or my dependent(s) to my insurance company, or to my attorney, now or in the future, and/or my physician(s), if necessary, for the purposes of billing, payment, or collection of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance company and to RoseSprings Medical.

\_\_\_\_\_  
 Patient or Authorized Person's Signature Date

**Payment agreement:** All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to me and I am responsible for all fees, regardless of insurance coverage. I understand that my insurance coverage is a contract between myself and my insurance company and that RoseSprings Medical is hereby willing to assist me in collecting those payments from my insurance company for my services. I understand I am responsible to RoseSprings Medical for charges not covered by this assignment, including deductibles and co-payment requirements by my insurance company policy, certificate of coverage, or for any unauthorized workers' compensation claims. I will bear the expenses of collection and/or court costs, and reasonable legal fees, should this be required. I understand if my commercial, health, or other insurance has not paid my medical bill within 60 days of my visit(s), for my services received from RoseSprings Medical, I am responsible, and I will then make whatever arrangements are necessary and available to me to pay all unpaid charges.

\_\_\_\_\_  
 Patient or Authorized Person's Signature Date

**Assignment of Benefits:** I hereby authorize payment of medical benefits to and assign to RoseSprings Medical all money to which I am entitled for medically related expenses received at or through RoseSprings Medical. The payment shall not exceed my total indebtedness for services received through RoseSprings Medical. Any payment that RoseSprings Medical received from the insurance company, beyond my indebtedness shall be refunded to me, when my outstanding bill(s) with them are paid.

\_\_\_\_\_  
 Patient or Authorized Person's Signature Date



### MASSAGE FEE SCHEDULE

The following table lists some of the most common CPT codes used by RoseSprings Medical and the amounts billed. Other codes may be used and are billed at UCR rates. The amounts billed may be adjusted from time to time.

Code	Description	Unit	Fee
97124	Massage Therapy	15 minutes	\$44.00
97140	Manual Therapy Techniques	15 minutes	\$50.00
97010	Hot or Cold Packs	session	\$10.00
97535	Self-Care / Home Management Instructions	15 minutes	\$58.00

I understand I may request a copy of any or all of my medical records for a reasonable fee or a fee allowed by State Statute or Workers' Compensation Statute.

\_\_\_\_\_  
 Patient or Authorized Person's Signature Date

### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.*

I acknowledge that RoseSprings Medical has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Region X, Office for Civil Rights  
 US Department of Health and Human Services  
 2201 Sixth Avenue, Suite 900  
 Seattle, WA 98121-1831  
 1-866-627-7748  
 TDD (206) 615-2296

I also understand that I am entitled to receive updates upon request if RoseSprings Medical amends or changes its Notice of Privacy Practices in a material way.

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

\_\_\_\_\_  
 Printed Name Relationship to Patient

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**This section is to be completed by practitioner when unable to obtain written acknowledgement from the patient.**

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgment.
- Other (specify): \_\_\_\_\_

\_\_\_\_\_  
 Practitioner Printed Name License Number

\_\_\_\_\_  
 Practitioner Signature Date