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

# WC MASSAGE 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 Social Security Number: _____

**Referring Physician**

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

**Employment**

Occupation: _____ Years Employed: _____

Employer at time of injury: _____

Address: _____

City: _____ State: _____ Zip: _____

Supervisor: _____ Phone: _____

Attorney's Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Claim Representative: _____ Phone: _____

**Nature of Accident**

Date and time of injury: Date: _____ Time: _____

Was this an auto accident? ☐ Yes ☐ No If yes, state in which accident occurred: _____

Injury reported to employer? ☐ Yes ☐ No

In your own words, please describe accident: _____

_____

_____

_____

I understand that once I am an authorized Workers' Compensation Patient, I am not to be billed, by you, your staff, or facility, for services, under any circumstances. The only exception is, unless I am required by law to pay a co-pay after reaching MMI, or unless I, or you are notified by the employer/carrier, through legal avenues that you have been de-authorized.

I understand that it is my responsibility to keep all of my appointments with you. I understand also that if I do not, or if I regularly miss appointments, it is then your obligation to notify the employer/carrier and my physician. To regularly or often miss my scheduled appointments is an indication that I may no longer need treatments and can therefore possibly jeopardize my case.

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

# WC 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

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

## 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 _____

**********

**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 _____