Trisha Stubblefield, LMP | 17311 135th Ave NE Suite A-250
Woodinville, WA 98072
(425)408-0040

Patient Information

Name_____
Date of Birth _____
Address _____
City/State/Zip _____
Home Phone _____
Cell _____ Work _____
Emergency Contact _____
Relationship_____ Phone _____

Primary Health Care Provider

Name _____
Address _____
City/State/Zip _____
Phone _____ Fax _____

*I give permission to Trisha Stubblefield, LMP to consult with my health care providers regarding my health and treatment.

_____ _____
Signature Date

Current Health Information

Check/Circle all that apply
Primary Health Concern _____
mild __ moderate __ disabling __
constant __ intermittent __
Symptoms increase/decrease with activity
Concern is worsening/improving/no change
Treatment(s) received _____

Secondary Health Concern _____
mild __ moderate __ disabling __
constant __ intermittent __
Symptoms increase/decrease with activity
Concern is worsening/improving/no change
Treatment(s) received _____

Addition Health Concern _____
mild __ moderate __ disabling __
constant __ intermittent __
Symptoms increase/decrease with activity
Concern is worsening/improving/no change
Treatment(s) received _____

List Daily Activities Limited by Condition

Work _____
Home/Family _____
Sleep/Self-Care _____
Social/Recreational _____

Self-Care Routines

How do you reduce stress? _____

Pain? _____

List current medications (include pain relievers and herbal remedies) _____
_____
_____

Have you ever received massage therapy? _____
Frequency?_____
What are your goals for receiving massage therapy?_____
_____

Health History

List and Explain. Include dates and treatment(s) received.

Surgeries_____
_____
_____
_____

Injuries _____
_____
_____
_____

Major Illnesses_____
_____
_____
_____

Check All Current and Previous Conditions Please Explain

General

current past comments

- ☐ ☐ headaches
- ☐ ☐ pain
- ☐ ☐ sleep disturbances
- ☐ ☐ fatigue
- ☐ ☐ infections
- ☐ ☐ fever
- ☐ ☐ sinus
- ☐ ☐ other

Skin Conditions

current past comments

- ☐ ☐ rashes
- ☐ ☐ athlete's foot, warts
- ☐ ☐ other

Muscles and Joints

current past comments

- ☐ ☐ rheumatoid arthritis
- ☐ ☐ osteoarthritis
- ☐ ☐ osteoporosis
- ☐ ☐ scoliosis
- ☐ ☐ broken bones
- ☐ ☐ spinal problems
- ☐ ☐ disk problems
- ☐ ☐ lupus
- ☐ ☐ TMJ, jaw pain
- ☐ ☐ spasms, cramps
- ☐ ☐ sprains, strains
- ☐ ☐ tendonitis, bursitis
- ☐ ☐ stiff or painful joints
- ☐ ☐ weak or sore muscles
- ☐ ☐ neck, shoulder, arm pain
- ☐ ☐ low back, hip, leg pain
- ☐ ☐ other

Nervous System

current past comments

- ☐ ☐ head injuries, concussions
- ☐ ☐ dizziness, ringing in ears
- ☐ ☐ loss of memory, confusion
- ☐ ☐ numbness, tingling
- ☐ ☐ sciatica, shooting pain
- ☐ ☐ chronic pain
- ☐ ☐ depression
- ☐ ☐ other

Respiratory, Cardiovascular

current past comments

- ☐ ☐ heart disease
- ☐ ☐ blood clots
- ☐ ☐ stroke
- ☐ ☐ lymphadema
- ☐ ☐ high, low blood pressure
- ☐ ☐ irregular heart beat
- ☐ ☐ poor circulation
- ☐ ☐ swollen ankles
- ☐ ☐ varicose veins
- ☐ ☐ chest pain, shortness of breath
- ☐ ☐ asthma

Allergies

current past comments

- ☐ ☐ scents, oils, lotions
- ☐ ☐ detergents
- ☐ ☐ other

Digestive/Elimination System

current past comments

- ☐ ☐ bowel problems
- ☐ ☐ gas, bloating
- ☐ ☐ bladder/kidney/prostrate
- ☐ ☐ abdominal pain
- ☐ ☐ other

Endocrine System

current past comments

- ☐ ☐ thyroid
- ☐ ☐ diabetes

Reproductive System

current past comments

- ☐ ☐ pregnancy
- ☐ ☐ painful, emotional menses
- ☐ ☐ fibrotic cysts

Cancer/Tumors

current past comments

- ☐ ☐ benign
- ☐ ☐ malignant

Habits

current past comments

- ☐ ☐ tobacco
- ☐ ☐ alcohol
- ☐ ☐ drugs
- ☐ ☐ coffee, soda

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____

Provider

BILLING INFORMATION

Patient Name _____ Date _____

Date of Injury _____ ID#/DOB _____

Billing Policy

Our office is set up to receive direct payment from insurance companies. For the best chance of reimbursement from your insurance carrier, we ask that you:

• Contact your insurance company to determine your manual therapy coverage and provider stipulations. Coverage depends on your insurance company and the specific plan you have chosen. We have provided a list of questions for you to ask your insurance representative or attorney that will help determine your eligibility for our billing service.

• You will need a current prescription for manual therapy from a primary health care provider, such as a physician or a chiropractor in order to submit your claim. Referrals are current for 90 days unless otherwise specified.

It is important that you understand your insurance policies in order for you to budget for your manual therapy services. You are personally responsible for all charges incurred in our office. We expect payment in full until your insurance coverage has been verified.

We realize that the completion of this form is an added burden to you as a consumer, and we thank you very much for your assistance. This completed form will provide both you and our billing department with important information regarding your manual therapy insurance benefits, and enable us to process your claim in a timely fashion.

Patient Information

Is patient's condition related to:

☐ auto collsion—In what state? _____
☐ other accident _____
☐ employment ☐ illness

Patient status: ☐ male ☐ female
☐ single ☐ married/partnered ☐ other

Patient relationship to insured
☐ self ☐ spouse/partner ☐ child ☐ other

Insured's Information (if other than patient)

Name _____
Address _____
City _____ State ____ Zip _____
Phone: _____
Date of birth _____
Sex: ☐ Male ☐ Female
Employer's Name or School Name _____
_____

Insurance Information

Insurance plan name or program name: _____
Member ID#: _____ Group #: _____
Customer service phone #: _____ Date and time you called: _____
Name of customer service representative: _____
Insurance claim address: _____ State: _____ Zip: _____
Does the plan include a Physical Medicine and Rehabilitation benefit? ☐ Yes ☐ No
Who may provide the services? ☐ Massage Therapist ☐ Physical Therapist ☐ Other
Is pre-authorization required? ☐ Yes ☐ No Who can authorize the services? _____
Is a prescription required? ☐ Yes ☐ No Is a referral required? ☐ Yes ☐ No
Who may refer? ☐ MD ☐ DC ☐ ND ☐ PT ☐ Other _____
How often does the referral need to be updated to ensure continuous coverage? _____
Is there a Preferred Provider list for Manual Therapists? ☐ Yes ☐ No
Is _____ on the list? ☐ Yes ☐ No

If this is a Workers' Compensation Claim, please fill out the following information:

Who is the attending HCP? _____ Phone: _____

Claim number: _____ Date eligibility began: _____

Number of visits authorized: _____ Number of visits remaining: _____

Dates of coverage: _____ Date claim closed: _____

If this is a Personal Injury Claim, please fill out the following information:

PIP policy amount: _____ Dates of coverage: _____ PIP available: _____

MedPay amount: _____ Dates of coverage: _____ MedPay available: _____

Liability amount: _____ Dates of coverage: _____ Liability available: _____

Uninsured/Underinsured (UMI) policy amount: _____ UMI available: _____

Has the PIP application been received? ☐ Yes ☐ No

Has an attorney been consulted? ☐ Yes ☐ No Retained? ☐ Yes ☐ No

Name/Firm _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

If this is a Private Health Insurance Claim, please fill out the following information:
(Or, if your Personal Injury claim defaults to secondary coverage, fill this out)

Maximum allowable benefit for Physical Medicine/Rehabilitation: _____

In network: $_____ # visits _____ Remaining $_____ # visits _____

Deductible: $_____ Satisifed to date: $_____ Co-Pay: $_____

Out-of-network: $_____ # visits _____ Remaining $_____ # visits _____

Deductible: $_____ Satisifed to date: $_____ Co-Insurance: $_____

Are these limits just for manual therapy? ☐ Yes ☐ No

If no, what other types of treatment do they include? _____
(i.e., chiropractic, physical therapy, occupational therapy, naturopathy, etc.)

Assignment of Benefits

My signature below authorizes and directs payment of medical benefits for services billed to my health care provider: _____

Release of Medical Records

My signature below authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney.)

Financial Responsibility

It is my responsibility to pay for all services provided. In the event that my insurance company denies payment or makes a partial payment, I agree to be and remain responsible for the balance. It is also my understanding and agreement that if you have contracted with my insurance company at a discount rate and the agreed-upon fee has been satisfied, the balance owed on those specific visits will be waived.

Signature _____ Date _____

PRIVACY POLICY ACT

I, Trisha Stubblefield, LMP, respect your privacy and understand that your health information is sensitive. I keep a record of the healthcare services I provide you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the record I keep. I will not disclose your medical information to others unless you direct me to do so or applicable laws authorize or compel me to do so. You, as my client, have the right to request further information regarding these laws. If you believe that information in your record is inaccurate, you may also request that we correct or amend that record. This request must be received in writing.

OTHER POLICIES & NOTES

I understand I must give notice of cancellation within 24 hours of my scheduled appointment. I will be charged a fee of $25.00 if proper notice is not given. Exceptions are at the discretion of the practitioner.

_____
Initial

I am responsible for all bills incurred during massage treatments. Payment is due on the date of service unless I have a work, auto or health insurance claim. The practitioner will provide initial billing to insurance companies; however I understand that all bills are my responsibility and payable within 60 days with a 5% monthly late fee for each month over 30 days. I understand my co-pay and deductibles are due and payable upon service. Lastly, I understand there will be a $25.00 NSF fee on all returned checks.

_____ _____
Signature Date

Trisha Stubblefield LMP
17311 135th AVE NE Suite A-250
Woodinville WA 98072
Phone 425-408-0040
Fax 425-408-0571

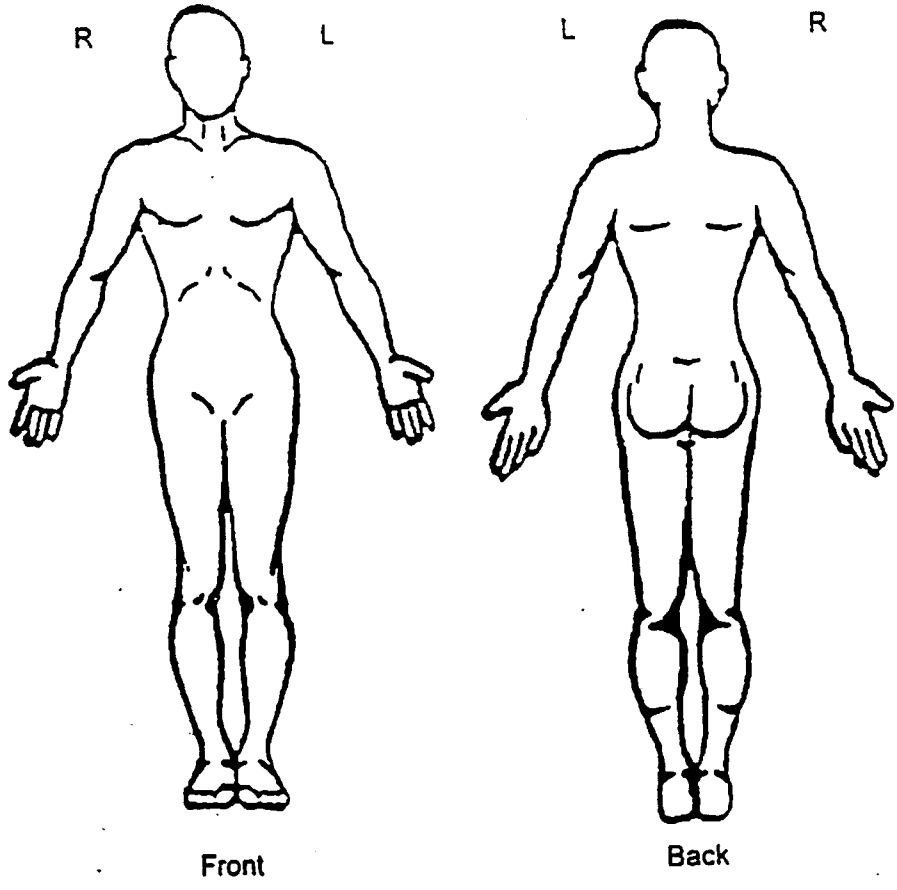
Symptom Diagram

Patient's Name: _____ File #:_____ Date: _____

In the diagrams provided below, please mark the areas on your body, which you feel best represents the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Also, in order to complete the picture, please draw in your face.

Symbols:

Numbness	≡	Pins & Needles	⁘
Burning	x x x x x x x x	Stabbing & Sharp	///
Dull & Aching	+ + + + + + + +	Stiff & Tight	2 2 2 2 2 2 2 2



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