Muscle Eze - Client Enrollment Form

Today's Date: ____/____/____

Name: _____ Date of injury: _____

Address:_____ City:_____ State_____ Zip_____

Home phone: (____) _____-_____ Work: (____) _____-_____ Cell: (____) _____-_____

E-mail: _____

Birthdate:_____/_____/_____ Age: _____ Sex: M / F Marital Status: S M D W

Employer: _____ Occupation:_____

Emergency contact: Name _____ Relationship _____ Phone: (____) ____-_____

Whom may we thank for referring you? _____ Relationship _____

If not a referral, how did you hear about us? _____

Have you ever received massage therapy? Yes [ ] No [ ]

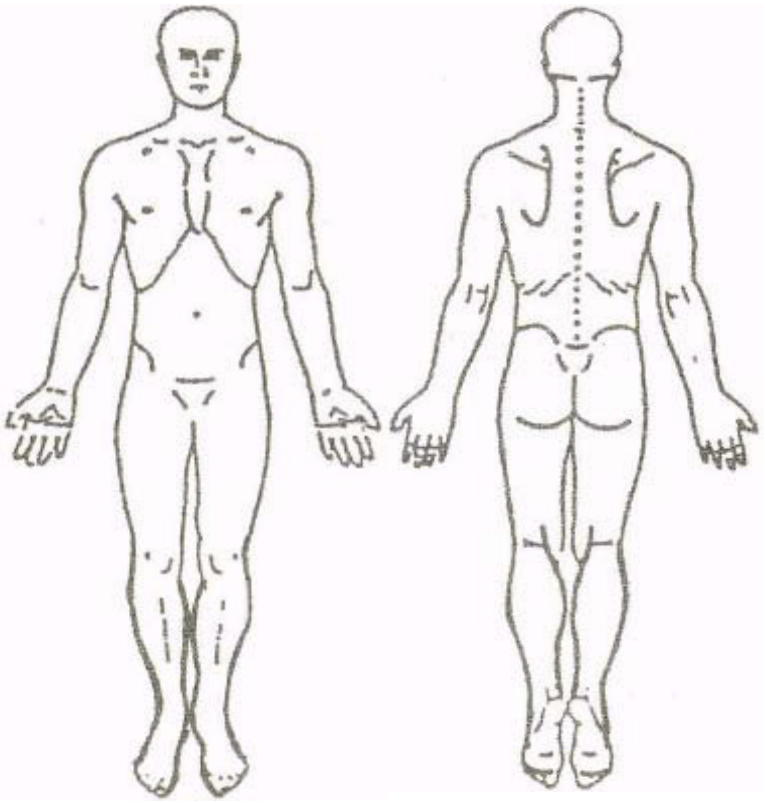
How often do you get massage? _____

Medical History (Please check all that apply)

[ ] Hypertension
[ ] Heart Disease
[ ] Diabetes
[ ] Arthritis
[ ] Headaches
[ ] Joint Pain
[ ] Edema
[ ] Allergies
[ ] Epilepsy
[ ] Low Blood Press
[ ] High Blood Press
[ ] Herniated Disks
[ ] Cancer
[ ] Varicose Veins
[ ] HIV/AIDS
[ ] Bursitis
[ ] Sciatic Pain
[ ] Sinusitis
[ ] Easy Bruising
[ ] Seizures
[ ] Phlebitis
[ ] Resent Surgery
[ ] TMJ
[ ] Back Pain

Since the Accident are you experiencing the following:

[ ] Breathing Difficulties
[ ] Sleep Disturbances
[ ] Neck Pain/Stiffness
[ ] Headaches
[ ] Upper Back Pain
[ ] Mid Back Pain
[ ] Low Back Pain
[ ] Dizziness
[ ] Numbing Tingling: Hands [ ] Arms [ ] Legs [ ]



(Please indicate with an X areas of your pain)

Are you pregnant? Yes [ ] No [ ]

Do you have any other medical conditions I should be aware of before you receive a massage? _____

Are you taking any medication? (please list) _____

Do you have any needs that require special attention? _____

AUTHORIZATION FOR THERAPY AND CONSENT FOR CARE

I understand and agree that I am personally responsible for payment of all services rendered. Health and accident policies are an arrangement between an insurance carrier and myself, however, Muscle Eze may accept certain insurance assignments of benefits. I understand and agree that I am ultimately responsible for any payment that my insurance carrier or any third party payer does not pay. The acceptance of insurance is individually determined and prior authorization is required. I understand that upon termination of care, any outstanding charges for professional services rendered will be immediately due and payable. I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

PATIENT SIGNATURE: _____DATE:_____

GUARDIAN SIGNATURE and relationship: _____

ASSIGNMENT OF BENEFITS

I, _____ Hereby authorize_____
(Name of Insured / client) (Name of Insurance Carrier)
to make medical benefits payments otherwise payable to me for services rendered by MUSCLE EZE, but not to exceed the charges of those services, payable to and mailed directly to:

Muscle Eze
2620 Manatee Ave West, Ste A
Bradenton, FL 34205

Furthermore, I hereby IRREVOCABLY ASSIGN to MUSCLE EZE the rights and benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by MUSCLE EZE.

IN WITNESS WHEREOF the undersigned have hereunto set their hands, this _____day of _____, 20__.

_____ _____
CLIENTS'S SIGNATURE CLIENT'S NAME (PLEASE PRINT)

* * * * * * * * * * * * * * *

AUTHORIZATION FOR RELEASE OF RECORDS

TO:_____ DATE:_____
_____ FROM: Muscle Eze
_____ 2620 Manatee Ave. West, Ste A
Bradenton, FL 34205

I authorize and request you to release any and all records in your possession concerning this client:

(Client Signature) _____ (Print Name)_____