Foster Wellness

Greg Lewerenz, EAMP, LMP • 4300 – 36th Ave W, Ste 130, Seattle WA 98199
(206) 856-4096 • info@fosterwellness.com

Patient Information – Massage

(please print and complete in full)

Name: _____ Today's Date: _____

Address: _____ Zip Code: _____

Home/Cellular Phone#: _____ Work Phone #: _____

Email address: _____@_____

Please indicate if I may leave messages for you at the following locations:

At your home telephone? Yes / No At your work telephone? Yes / No Via email? Yes / No

Date of Birth: _____/_____/_____ Age: _____ Gender: _____
Month Day Year

Emergency Contact: _____Emergency Contact Phone #:_____

Who may I thank for referring you to Foster Wellness? _____

Occupation:_____

Employer's Name: _____Telephone #: _____

Address:_____

Spouse's/Partner's Name (or insured parent):_____

Address & Phone # (only if different from above): _____

Physician's Name: _____Telephone #: _____

Physician's Address: _____Date of last visit: _____

Primary Insurance:[1] _____Telephone #: _____

Insurance Billing Address: _____

Policy Holder's Name: _____Relationship:_____DOB:_____

Policy # / ID #: _____Group #: _____

Secondary Insurance:_____Telephone#:_____

Insurance Billing Address: _____

Policy Holder's Name: _____ Relationship:_____

Policy # / ID #: _____Group #: _____

[1] Note: If utilizing your insurance benefits, please confirm your eligibility with your insurance provider prior to your first visit.

Medical History and Current Presentation

Patient Name: _____Date: _____

Have you ever had massage? When and for what reason?_____

_____

Are you presently being treated for a medical condition? Please describe._____

_____

What main health issue do you want treated? Please describe as fully as possible, including when the condition first manifested:_____

_____

_____

_____

What treatment have you been using for relief of this issue?_____

_____

Do you have other health concerns? If so, please describe_____

_____

Major hospitalizations and/or surgeries

Year Operation/illness/surgery

Are you currently pregnant or have you recently given birth? Yes / No

If yes, when is the due date or when did you give birth? _____

Medicines - *Check any medications you are currently taking.*

Aspirin____ Ibuprofen____ Acetaminophen (Tylenol)____ Antacids____ Laxatives____ Cold tablets____ Diet Pills____

Oral contraceptives____ Tranquilizers____ Sleeping Pills____ Hay fever tablets____ Blood pressure pills____

Blood thinning pills____ Insulin/diabetic pills____

Other_____

Vitamins (please list):

_____

Herbs/Supplements (please list):

_____

Drug and/or other allergies:

_____

Other History - *Please check conditions you have had in the past or have currently.*

General

	past	current
Poor appetite		
Excessive appetite		
Change in appetite		
Fatigue		
Fevers		
Night sweats		
Sweat easily		
Chills		
Poor coordination		
Insomnia		
Strong Thirst		
Other:_____		

Skin and Hair

	past	current
Rashes		
Hives		
Itching		
Eczema		
Pimples		
Dryness		
Tumors, Lumps		
Other:_____		

Head/Neck/Eyes/Ears

	past	current
Dizziness		
Fainting		
Neck stiffness		
Headaches/Migraines		
Poor memory		
Concussion(s)		
Blurred vision		
Visual changes		
Poor night vision		
Spots in eyesight		
Cataracts		
Glasses/contacts		
Eye Inflammation		
Ear infection		
Ringing		
Decreased hearing		
Other:_____		

Nose/Throat/Mouth

	past	current
Nose bleeds		
Sinus infection		
Hay fever or allergies		
Frequent sore throats		
Grinding teeth		
Difficulty swallowing		
Dry mouth/throat		
Teeth problems		
Copious saliva		
Facial pain		
Gum problems		
Other:_____		

Respiratory

	past	current
Asthma		
Bronchitis		
Frequent colds		
Pneumonia		
Emphysema		
Cough		
Coughing blood		
Production of phlegm		
Other:_____		

Cardiovascular

	past	current
High Blood Pressure		
Low Blood Pressure		
Blood clots		
Palpitations		
Phlebitis		
Chest pain		
Irregular heart beat		
Cold Hands/Feet		
Swelling of Hands/Feet		
Other:_____		

Gastro-Intestinal

	past	current
Nausea		
Vomiting		
Belching		
Bad breath		
Indigestion		
Gas		
Constipation		
Diarrhea		
Blood in stools		
Black stools		
Rectal pain		
Hemorrhoids		
Pain or cramping		
Gall bladder disorder		
Other:_____		

Musculoskeletal

	past	current
Injury		
Joint pain		
Muscular pain		
Back pain		
Localized weakness		
Strain		
Broken bone(s)		
Atrophy		
Other:_____		

Gynecology

	past	current
Frequent UTIs		
Vaginal infection(s)		
Genital pain/itching		
Abnormal Pap smear		
Irregular periods		
Painful menstruation		
Premenstrual syndrome		
Abnormal bleeding		
Menopause syndrome		
Breast lumps		
Other:_____		

Male Reproductive

	past	current
Genital pain/itching		
Genital lesions		
Weak urinary stream		
Lumps in testicles		
Impotence		
Other:_____		

Genito-Urinary

	past	current
Pain on urination		
Frequent urination		
Urgency to urinate		
Unable to hold urine		
Blood in urine		
Kidney stones		
Other:_____		

Neurological

	past	current
Seizures		
Tremors		
Numbness/Tingling		
Pain		
Paralysis		
Other:_____		

Psychological

	past	current
Depression		
Anxiety/Stress		
Panic attacks		
Addictions		
Eating disorder		
Irritability		
Anger		
Treated for emotional/ psychological issues		
Other:_____		

Cancer/Tumors

	past	current
Benign		
Malignant		

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Patient Treatment Consent, Payment and Cancellation Agreement

Patient's Name:_____

Date of Birth: _____Age:_____

I, the undersigned, hereby consent for Foster Wellness to perform manual therapy, including massage, on me (or on the patient named above for whom I am legally responsible). I understand that methods of massage treatment may include, but are not limited to: Swedish (petrissage and effleurage), trigger point (holding points of tight tissue to achieve myofascial release), deep tissue (slower and deeper strokes in smaller areas as compared to Swedish techniques), Chinese tuina (including acupressure, rolling, tapotement, and other techniques to bring the body into balance), and stretching (passive or active movements to lengthen muscular tissue).

I understand that the beneficial effects associated with these treatments include decreased pain, reduced muscle spasm, and improved mobility. I understand there is no certainty that I will achieve these benefits.

I have reported all health conditions that I am aware of and I will inform my practitioner of any changes to my health prior to my next treatment, including, but not limited to, being diagnosed with a severe bleeding disorder or cancer (whether benign or malignant), receiving a pacemaker, or if I become pregnant.

I understand that there are some very slight risks associated with massage, including but not limited to bruising and muscle soreness.

I agree to follow the advice given to me by my massage practitioner. I understand I might be dropped from the program for refusal to do so.

I understand that reasonable alternatives to the treatments described above include the following:

Medications: I understand that medications can be used to reduce pain. I also understand that medications may produce inadequate relief, side-effects, and physical or psychological dependence.

Surgery: I understand that surgery can reduce pain associated with certain conditions. I also understand that surgery may lead to unsuccessful outcome, complications, and side effects related to anesthesia.

Non-treatment: I understand the risks for non-treatment may include increased pain.

I understand that a $40 late fee may be incurred for a cancellation within 24 hrs of my appointment; this fee will be paid by me and cannot be billed to my insurance plan. If I have medical insurance, I hereby authorize and assign my insurance benefits to be paid directly to Foster Wellness. I understand that I am financially responsible for any services not covered by insurance. I also authorize Foster Wellness to release information in order to process any claims.

I hereby certify that I have read (or have had it read to me) and understand all of the above. I may have a copy of this form for my records upon request.

Signature:_____Date:_____
(If patient is a minor, please have parent /guardian sign)

Clinician:_____Date:_____
Greg Lewerenz, EAMP, LMP
Washington State Acupuncture License #AC60114046
Washington State Massage License #MA00023193
Seattle Institute of Oriental Medicine, Masters of Oriental Medicine, Sept. 2006-Aug. 2009

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice (which may be amended from time to time).

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Permissible Uses and Disclosures Without Your Written Authorization. We may use and disclose PHI without your written authorization for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are legally permissible.

1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may review and use your medication history to diagnose, treat, and provide medical services to you. In addition, we may disclose PHI to other health care providers in order to provide you with appropriate care and continued treatment.

2. Payment: We may use or disclose PHI for the purposes of determining coverage, billing, claims management, and reimbursement. For example, a bill sent to your health insurer may include information about a treatment you received so that the insurer will pay us for the treatment. We may also inform your health plan about a treatment you are going to receive in order to determine whether the plan will cover the treatment.

3. Health Care Operations: We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff. We may also disclose PHI to our health care professionals for review and learning purposes.

4. Required or Permitted by Law: We may use or disclose PHI when we are required or permitted to do so by law. For example, we may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition we may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures for workers' compensation claims, and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions as authorized by law.

B. Uses and Disclosures Requiring Your Written Authorization.

1. Psychotherapy Notes. We must obtain your authorization for any use or disclosure of psychotherapy notes, except if our use or disclosure of psychotherapy notes is: (1) by the originator of the psychotherapy notes for treatment purposes, (2) for our own training programs in which mental health students, trainees or practitioners learn under supervision to practice or improve their counseling skills, (3) to defend ourselves in a legal proceeding initiated by you, (4) as required by law, (5) to a health oversight agency with respect to the oversight of the originator of the psychotherapy notes, (6) to a coroner or medical examiner; or (7) to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public.

2. Marketing Communications; Sale of PHI. We must obtain your written authorization prior to using PHI for marketing or the sale of PHI, consistent with the related definitions and exceptions set forth in HIPAA.

3. Other Uses and Disclosures. Uses and disclosures other than those described in this Notice will only be made with your written authorization. For example, you will need to sign an authorization form before we can send PHI to your life insurance company or to your attorney. You may revoke any such authorization at any time by providing us with written notification of such revocation.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical records and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records. We may charge a fee for the costs of copying and sending you any records requested.

B. Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI we use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer of Foster Wellness at 4300 - 36th Ave. W., Suite 130, Seattle, WA 98199. We are not required to agree to any such restriction you may request, except if your request is to restrict disclosing PHI to a health plan for the purpose of carrying out payment or health care operations, the disclosure is not otherwise required by law, and the PHI pertains solely to a health care item or service which has been paid in full by you or another person or entity on your behalf.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of disclosures of PHI made by us in the last six years, subject to certain restrictions.

E. Right to Request Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by contacting the Foster Wellness Privacy Officer at 206-856-4096.

G. Right to Receive Notification of a Breach. We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.

H. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the Foster Wellness Privacy Officer at 206-856-4096**.** You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on April 20, 2014

B. Changes to this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in the waiting area of our office and on our web site at http://www.fosterwellness.com. You may also obtain a revised notice by contacting the Foster Wellness Privacy Officer at 206-856-4096.

I acknowledge having received a copy of this Notice of Privacy Practices describing how medical information about me may be used and disclosed and my rights regarding this information.

Signature of Patient (or legal guardian) Date