Integrative Arts
Gary Wass, LMT & Sarah Blattler, LMT
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509.240.6989

Name ______________________ Date ____________

Date of Birth ____________ Pronoun preferance ____________

Are we billing your insurace ☐ Yes ☐ No

If we are billing insurance, please provide your gender as noted with insurance company: ________

Address ______________________

City ____________ State ________ Zip ________

Cell ____________ Work ____________ Home ____________

Email Address ______________________

Do you care for a reminder? ☐ Yes ☐ No

Phone ☐ Email ☐ Test ☐

How Did You Hear About Our Clinic?

☐ Online ☐ Insurance Referral ____________

Marital Status: ☐ Married ☐ Single ☐ Other ____________

Have you had a massage before? ☐ Yes ☐ No

What symptoms are you experiencing that made you seek therapeutic body work?

______________________

______________________

What results would you like to achieve from your treatments?

______________________

What types regular exercise do you paricipate in and how often? ____________

______________________

Rate your stress on a scale of 1 - 10 (10 is high) ____________

List any medications and condition it is treating ____________

______________________

______________________

Have you recently been hospitalized, ill, or injured? If yes, explain:

______________________

## Insurance Information

Subscribers Name ______________________ Date of Birth ____________

Relationship to patient ______________________ Subcribers SSN ____________

Condition related to ☐ Auto ☐ Work ☐ Neither Date of Inury ____________

Insurance Name: ______________________

ID Number ______________________ Group Number ____________

Referrig Doctor ______________________

Check any of the following conditions you have had in the past, currently have or are being treated for:

- [ ] Headaches
- [ ] Eye Strain
- [ ] Sinus Problems
- [ ] TMJ
- [ ] Insomnia
- [ ] Seizures
- [ ] Cancer
- [ ] Digestive Problems
- [ ] Ulcers
- [ ] Elimination Problems
- [ ] Skin Cisease
- [ ] Compromised Immunity
- [ ] Blood Clots
- [ ] Vericose Veins
- [ ] Heart Problems
- [ ] Communicable Disease
- [ ] Eating Disorders
- [ ] Kidney Disease
- [ ] Arthritis
- [ ] High/Low Blood Pressure
- [ ] Diabetes
- [ ] Back Problems
- [ ] Fractures
- [ ] Torn Cartilage
- [ ] Dislocated Joints
- [ ] Alergies
- [ ] Asthma
- [ ] Ehlers-Danlos Syndrom
- [ ] Others:

Additional Information:

Please share any additional information you feel is important to your care.

## Consent to Receive Care

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there no impled or stated gurantee of success of effeciveness of indvidual techniques or series of appointments. I acknowledge that massage therapyis not a substitute for medical care, medical examination or diagnosis. I have state all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

## Assignment of Benefits - Authorization to bill insurance

I hereby authorize Gary L. Wass, LMT to furnish the above information to insurance carriers and irrevocably assign all payment for massage therapy services renderded. I understand that any eneftis quoted by my insurance company are not a guarantee of payment. I understand that I am financially responsible for all denied claims or claims not paid by my insurance company.

______________________________ ______________
Patient Name (please print) date

______________________________
Patient Signature

______________________________ ______________
Responsible Party Signature (parent or gardian if patient is a minor) date