## Integrative Arts Gary Wass, LMT & Sarah Blattler, LMT 2929 SW Multnomah Blvd. #207 Portland, OR 97219 509.240.6989

Name		Date		
Date of Birth Pron	oun preferance			
Are we billing your insurace Yes	No			
If we are billing insurance, please provide your gend	ler as noted with insurance compa	ny:		
Address		·		
City	State	Zip		
Cell	Work	Home		
Email Address	·			
Do you care for a reminder?	No			
Phone Email	Test			
How Did You Hear About Our Clinic?				
Online Insurance Refe	rral			
Marital Status: Married Sing	gle 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 tr	eatments?			
What types regular exercise do you paricipate in an	d how often?			
TYTIAL types regular exercise do you paricipate in air	a now orten:			
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:			
<u>Ir</u>	nsurance Information			
Subscribers Name	D	ate of Birth		
Relationship to patient	entSubcribers SSN			
Condition related to Auto	Work Neither Date o	f Inury		
Insurance Name:				
ID Number	Group	Number		
Referrig Doctor		•		

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	Check any of the following conditions you have had in the past, currently have or are being treated for:				
Sinus Problems Blood Clots Fractures  TMJ Vericose Veins Torn Cartilage Insomnia Heart Problems Dislocated Joints  Seizures Communicable Disease Alergies  Cancer Eating Disorders Asthma Digestive Problems Klidney Disease Ehlers-Danlos Syndrom Ulcers Arthritis Others: Elimination Problems High/Low Blood Pressure  Additional Information: Please share any additional information you feel is important to your care.  Consent for massage. I understand that there no impled or stated gurantee of success of effectiveness of indvidual techniques or series of appointments. I acknowledge that massage therapy is 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.	Headaches	Skin Cisease	Diabetes		
TMJ Vericose Veins Torn Cartilage Insomnia Heart Problems Dislocated Joints Selzures Communicable Disease Alergies Cancer Eating Disorders Asthma Digestive Problems Kidney Disease Ehlers-Danios Syndrom Ulcers Arthritis Others: Ellmination Problems High/Low Blood Pressure  Additional Information: Please share any additional information you feel is important to your care.  Consent for massage. I understand that there no impled or stated gurantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is 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.	Eye Strain	Compromised Immunity	Back Problems		
Insomnia Heart Problems Dislocated Joints  Seizures Communicable Disease Alergies  Cancer Eating Disorders Asthma  Digestive Problems Kidney Disease Ehlers-Danios Syndrom  Ulcers Arthritis Others:  Ellimination Problems High/Low Blood Pressure  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 effectiveness of individual 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 renderedd. 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.	Sinus Problems	Blood Clots	Fractures		
Seizures Communicable Disease Asthma Cancer Eating Disorders Asthma Digestive Problems Kidney Disease Ehlers-Danlos Syndrom Ulcers Arthritis Others: Elimination Problems High/Low Blood Pressure  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 effectiveness of individual 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.	TMJ	Vericose Veins	Torn Cartilage		
Cancer	Insomnia	Heart Problems	Dislocated Joints		
Digestive Problems	Seizures	Communicable Disease	Alergies		
Ulcers High/Low Blood Pressure  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 effectiveness of individual 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 satus.  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.	Cancer	Eating Disorders	Asthma		
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Patient Name (please print) date					
	Toponoisio for all dolling claims of all	anno not paid by my modraneo e			
Patient Signature	Patient Name (please print)	***************************************	date		
Patient Signature					
	Patient Signature				
Responsible Party Signature (parent or gardian if patient is a minor) date	Responsible Party Signature (par	ent or gardian if patient is a min	or) date		