Kaimuki Health & Wellness
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Confidential Health Intake Form

Name _____ Date of Birth _____

Street Address/Apt Number _____

City_____ State_____ Zip_____ Contact Phone Number_____

Emergency Contact _____

Occupation/employer _____

Email _____

Insurance Information:

Referring Physician:_____ Primary Care Physician:_____

Was Injury a result of an accident?_____ If yes: Job related_____ Auto _____ Other_____

Date of Injury or onset: _____

Insurance Company Name:_____

Billing Address:_____

Phone Number:_____

Contact person/ case manager _____

Name of Insured :_____

Address:_____

Phone:_____

Group/Claim Number/Id number: _____

Attorney (if applicable) Name :_____

Address:_____

Phone number: _____

I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

_____I agree to provide **24 hour** cancellation notice. If I fail to do so, I agree to pay the **full** appointment fee. (Please note that insurance companies **do not** pay this, you do.)

Signature _____ Date _____

Massage Therapy Informed Consent

I, _____, (client) understand that massage therapy provided by, _____, (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below: (example: Auto/Workers' Compensation Injuries, Shoulder Impingement, Thoracic Outlet Syndrome, etc.)

_____

_____

I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Caregiver for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I give my consent to receive treatment. I understand them and agree to abide by them.

_____ _____

Client Signature Date