

**BERGKAMP-ENGLE MESSAGE**  
Confidential Client Data

Name: \_\_\_\_\_ Today's Date \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Which contact phone number do you want messages left on? Home Work Cell

Email Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status: M S W D Name of Spouse \_\_\_\_\_ Spouse DOB \_\_\_\_\_

Referred to our Office by \_\_\_\_\_ Feist SBC User Friendly

Massage Specifications

What areas do you want the massage to focus on? \_\_\_\_\_

What areas do you **not** want to be massaged? \_\_\_\_\_

Have you had a massage before and when? \_\_\_\_\_

Current Health Status

What complaints bring you in our office? \_\_\_\_\_

Does the pain move anywhere? \_\_\_\_\_ where? \_\_\_\_\_

On a scale of 1-10 (1-mild and 10-extreme pain) your rating would be? \_\_\_\_\_

What part of your lifestyle does your complaint interfere with? \_\_\_\_\_

Do you have any of the following today? Skin rash \_\_\_\_\_ Cold/Flu \_\_\_\_\_ Open Cuts \_\_\_\_\_

Severe Pain \_\_\_\_\_ Injuries/Bruises \_\_\_\_\_ Anything Contagious \_\_\_\_\_

Medical/Family History

What condition (s) have you been previously diagnosed with? \_\_\_\_\_

Family History: Heart Disease Diabetes Cancer Arthritis Other? \_\_\_\_\_

Have you had any accidents and when? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ Have you broken any bones? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

Is there anything else I should know about you medically? \_\_\_\_\_

The statements made above are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation and treatment.

HIPAA Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for: treatment, payment, and health care operations. I understand your HIPAA Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### INFORMED CONSENT

I hereby request and consent to the performance of massage therapy, including various modes of muscle, heat, cold and stretch therapy performed by a Massage Therapist at Bergkamp-Engle Chiropractic.

I understand and am informed that, as in the practice of massage therapy, there are some risks to treatment, including but not limited to, muscle strains, soreness, bruising, strokes, dehydration and “flu like” symptoms. I do not expect the massage therapist to be able to anticipate and explain all of the risks and complications and wish to rely on the massage therapist to exercise her judgment during the course of the treatments which the massage therapist believes at the time, based upon known facts, are in my best interest.

Massage therapy is a therapeutic aide to health care, and therefore, the massage therapist cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. I further understand that massage therapy is not a replacement for medical care and that no diagnosis will be made. The massage therapist will always give you her best care, and if results are not acceptable or if condition requires another fields expertise, she will refer you to another health care provider whom we feel will assist your condition more effectively.

I have read, or have had read to me, the above informed consent. I have also had the opportunity to ask questions about their content, and by signing below, I agree to the above named procedures. I give my consent that this form will cover the entire course of my treatment for my present and for future condition(s) for which I seek treatment.

We have a 24 hour cancellation policy for all massage sessions. If you cannot make your appointment please contact the office 24/7 at 682-6161 to leave a message. If your allotted time is not filled, you are responsible to pay half of the missed session fees.

Client’s Consent:

Client’s Guardian (if necessary):

\_\_\_\_\_  
Print Client’s Name

\_\_\_\_\_  
Print Client’s Guardian Name

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature of Client’s Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian’s Relationship to Client

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Health Information Technology for Economic and Clinical Health Act  
HITECH Acknowledgement and Consent Form

Under the HITECH Act, we must comply with the restriction request in certain circumstances [if the disclosure is to a health plan for purposes of carrying out payment or health care operations (not treatment) and the PHI pertains solely to a health care item or service for which the health care provider has been paid in full].

Patients have the right to restrict us from providing your spouse with information, and other such restrictions on uses and disclosures. Other rights include a right to request an alternate means by which to communicate such as to a post office box and not to a patient's residence or place of employment. We will comply with alternative email communication requests as this is a reasonable method of communication.

Sometime after January 1, 2011 and before January 1, 2014 (date to be determined by the Health and Human Services) you will have the right to an accounting of all disclosures. You also have the right of access in electronic form of your EHR.

I authorize Bergkamp Chiropractic and its agents to disclose my information.  
**I authorize the following person to receive my information (must be 18 years old):**

\_\_\_\_\_ **Relationship** \_\_\_\_\_

I authorize the following information to be used or disclosed on my behalf:

- ALL my information** including health and financial information OR
- ONLY limited information** (mark all applicable blocks below):
  - Benefits & Coverage
  - Billing
  - Claims & Payments
  - Diagnosis & Procedure
  - Eligibility
  - Financial
  - Physician & Hospital
  - Pre-certification
  - Pre-authorization
  - Referral
  - Treatment
  - Medical Records
  - Behavioral Health
  - Other: \_\_\_\_\_
  -

The following types of sensitive information will NOT be disclosed:  
*abortion, abuse (sexual/physical/mental), alcohol/substance abuse, genetic testing, HIV or AIDS, maternity, mental health, sexually transmitted or other communicable diseases or other such information.*

The purpose of my authorization is to disclose the information at my request. If not previously revoked, this authorization will terminate upon an updated version of this form.

\_\_\_\_\_  
Patient Signature Date

MINOR CHILD NAME(S): \_\_\_\_\_

Legal Representative Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_