Maya Whole Health Studio

GENERAL INFORMATION

Name _____ Today's Date _____

Date of Birth _____ (Please check one) Male _____ Female _____

Address:_____ City _____ State _____ Zip_____

Phone (1) _____ (2) _____ E-mail _____

Emergency Contact Name: _____ Phone _____

Occupation_____Employer_____

How did you find Maya Whole Health Studio? _____

INSURANCE INFORMATION *Please fill out whichever portion(s) apply*

Prescription from a physician is required for massage services to be billed by Maya Whole Health Studio.
Prescription Provided? Please circle: YES NO

Health/Medical

Insurance Company _____

ID# _____ Group # _____

Name of Primary Insured _____Date of Birth _____

Referring Practitioner (if applicable) _____

Auto Accident (PIP) or Labor and Industries (L&I) Claim

Date of Injury _____ Claim # _____

Insurance Company _____Phone _____

Address of Company _____

Name of Claim Adjuster _____

Referring Physician (if applicable) _____

Notice: Upon your request, Maya Whole Health Studio provides courtesy billing to your insurance provider for your services. If for any reason, benefits are denied or delayed for services that have been provided, you will be billed for the balance on the account. We thank you for your cooperation and understanding.

1322 Lake Washington Blvd N Suite 3 Renton, WA 98056
Direct 425.271.0200 :: Fax 425..206.309.3383 :: www.mayawholehealth.com

Maya Whole Health Studio

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.

Maya Whole Health Studio at Southport respects your privacy and understands that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information created and obtained while providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows use and disclosure of your protected health information for purposes of treatment and health care operations. State law requires your authorization to disclose this information for payment purposes.

Examples of Use and Disclosure of Protected Health information for Treatment, Payment, and Health Operations

Information obtained by members of our health care team will be recorded in your medical record and used to help decided what care may be right for you. We may also provide information to others providing care to you. This will help them stay informed about your care.

Health plans need information from us about your medical care if we are requesting payment from them. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefit services.

Your Health Information Rights

The health and billing records I create and store are property of Maya Whole Health Studio at Southport. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, ask questions about this notice
- Ask in writing to restrict certain uses and disclosures. We are not required to agree to those restrictions, but will review your request and inform you to any action taken
- Request in writing that you be allowed to see a copy of your protected health information
- Have us review a denial of access to your health information – except in certain circumstances
- Ask in writing to change your health information. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included in any release of your records
- Cancel prior authorization to use or disclose health information by providing a written revocation

Our responsibilities Include

Following the terms of this notice. However, we have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this notice. You may receive the most recent copy of this notice by calling and asking for one.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of family and others:
Unless you object, health information about you may be released to a friend or family member who may be involved in your medical care.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it. We may ask you to provide a written statement listing persons with whom you wish your health information to be shared, and those to whom you do not wish your information to be given.

Possible Disclosure of your Protected Health Information Without your Authorization

For public health and safety purposes as allowed or required by law

To report suspected abuse or neglect to public authorities

For law enforcement purposes such as when we receive a subpoena, court ordered, or other legal process, or you are the victim of a crime

For health and safety oversight activities

For disaster relief purposes

Uses and disclosures not on this notice will be made only as allowed or required by law or with your written authorization.

If you have any questions about this notice, want more information, or want to report a problem about the handling of your protected health information you may contact:
Maya Whole Health Studio at Southport
1322 Lake Washington Blvd Ste. 3
Renton, Wa. 98056
425.271.0200

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to oyhers unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Maya Whole Health Studio.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name Relationship (if signed on behalf of the patient)

Under no circumstances will your private health information be exchanged or sold to private vendors.

Maya Whole Health Studio

Health Care Waiver & Payment Agreement Policy

24 hour notice is required to cancel an appointment with no financial penalty

I understand that I am fully responsible for the payment of fees associated with services I receive at Maya Whole Health Studio. **Initial** _____

It is my responsibility to confirm that my insurance coverage will adequately cover any treatments I receive at Maya Whole Health Studio. I agree to pay for any reasonable and warranted charges for treatment received that is not ultimately covered by insurance provider. **Initial** _____

In the event that a 3rd party payer does not meet financial obligations for payment of fees for services that I receive at Maya Whole Health Studio, I will be accountable to make payment of any balance (or make arrangements to do so) within 30 days of notice. **Initial** _____

In the event that I disagree with any charges made by Maya Whole Health Studio for services that I receive, I will contact the Studio Coordinator to address the matter within 30 days of receiving notice of my obligation to pay charges. If charges are found to be reasonable and valid by Studio Coordinator, I will make arrangements for timely payment of account balances. **Initial** _____

In the event of a "no-show" I will be charged the full amount of the service scheduled. If I cancel within 24 hours of scheduled appointment, I may be charged 50% of the missed treatment. **Initial** _____

If I arrive late for an appointment, I understand that I may not receive services, or that I may receive partial services, due to need for practitioner to accommodate others on the schedule.

I certify that all information I have provided is true to the best of my knowledge and I understand and agree with the payment policy and cancellation procedures.

I understand that the services received at Maya Whole Health Studio are not considered to be conventional medical care and that these services do not serve as a substitute for emergency medical care.

I will inform my practitioner at Maya Whole Health Studio in a timely manner of any change in my physical health that could be attributed to any treatment provided.

I understand that the services provided at Maya Whole Health Studio are for the purpose of aiding in health maintenance and are non-sexual in nature.

I take full responsibility for how I proceed in regard to addressing any health concerns presented to practitioners at Maya Whole Health Studio. Any information provided by any practitioner at Maya Whole Health Studio is for educational purposes only.

By signing this form I waive any and all claims, damages, action and liabilities against Maya Whole Health Studio arising out of, or relating to any acupuncture, massage, or skincare services and allergic reactions to products and services suggested or sold.

Signature: _____ Date: _____

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MASSAGE CURRENT CONDITION INTAKE

Name _____ Date _____

Current Occupation: _____

Have you ever received a professional massage? € Yes € No If yes, when? _____

What degree of pressure do you generally prefer for bodywork?

€ Light € Medium € Firm/Deep € Varied

Indicate which result(s) you are primarily seeking from this massage treatment:

€ Relaxation/General Stress Relief € Decreased discomfort or pain € Increase circulation

€ Increase range of motion € Other Health Benefits: _____

Please mark any conditions that are current:

€ Headaches/Migraines € Claustrophobia € Cold/Flu (prior 2 days) □ Pace Maker

€ Alcohol Consumption (prior 24 hours) □ Bleeding disorder

□ Blood Thinning Medication □ Pregnancy _____ weeks

Do you have any sensitivities/allergies to any products, scents, or food items? € Yes € No

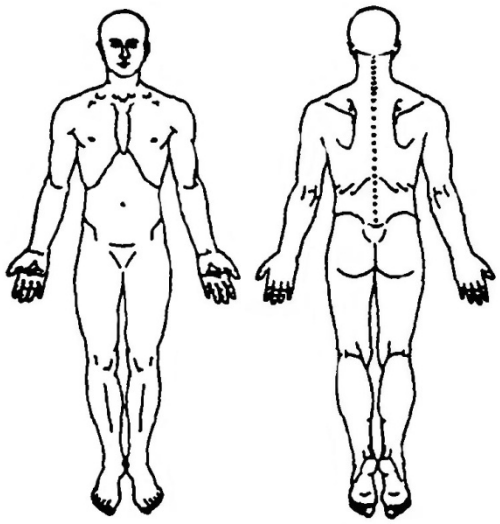
List: _____

Regular exercise? €Yes €No Type: _____Frequency:_____

If relevant, please rate your current level of pain (circle one):

(No Pain) 1 2 3 4 5 6 7 8 9 10 (extreme Pain)

Please mark on figure below and note any symptoms are affecting what areas of the body, including the nature of any pain (ie. dull ache, sharp jabbing, stinging, throbbing, cramping) and whether any areas are numb or tingling :



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Client Health History Information

Name: _____ Date: _____

General information

Please list any medications or supplements that you regularly use or have used in past months (including any that can thin blood, such as Coumadin, ibuprofen, garlic capsules, Vitamin C)

_____

_____

_____

_____

Please list any significant trauma, injuries, surgeries, or significant dental work, with approximate dates:

_____

_____

_____

_____

_____

Please check all that apply currently or in past, and circle those that are current issues.

- € Pregnant: weeks ____
- € Pacemaker
- € Bone or Joint Issues
- € Arthritis/ Gout
- € Lupus
- € Sprains/Strains
- € Varicose veins
- € High/ Low Blood Pressure
- € Irritable bowel syndrome
- € Breathing difficulty/Asthma
- € Bleeding Disorder/Clots
- € Prosthetics
- € Tendonitis/ Bursitis
- € TMJ
- € Spinal concerns
- € Heart Conditions
- € Lymphedema
- € Vertigo
- € Ulcers
- € Emphysema
- € Allergies specify: _____
- € Sinus Condition
- € Shingles
- € Numbness/Tingling
- € Pinched Nerve
- € Multiple Sclerosis
- € Fibromyalgia
- € Rashes
- € Athletes Foot
- € Ovarian/Menstrual problems
- € Prostate Condition
- € Bladder kidney Ailment
- € Menopause
- € Cancer _____
- € Chronic fatigue
- € Chronic Pain
- € Sleep disorders
- € Depression
- € Headaches/ Migraines
- € Stress/Anxiety
- € Contact lenses (hard or soft)
- € Diabetes
- € HIV/AIDS
- € Hepatitis
- € Human PapilloVirus
- € Thyroid Disease
- € Seizures
- € Rheumatic Fever
- € Other Significant Illness/Trauma:

_____

_____

_____

_____

_____

_____

Family History (immediate family, within two generations):

- € Diabetes
- € Thyroid Disease
- € Cancer
- € Heart Disease
- € High Blood Pressure
- € Stroke

I have completed this form to the best of my knowledge.I understand that all of the information provided is for use by Maya Whole Health Studio practitioners to support the improvement and/or maintenance of my health. I understand that this information will be made available to all Maya Whole Health practitioners who are engaged to provide services for me in efforts to improve and maintain my health.

Name _____ Date _____

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