4796 Canton Dr. Suite 400
Marietta, GA. 30066
770-926-9488
office@southcherokeechiropractic.com
www.southcherokeechiropractic.com

Covid-19 Policy

Have you traveled recently, or have been exposed to Covid-19 to the best of your knowledge?
[Yes] [No] Initials: _____

Are you experiencing any of the following symptoms? (Circle All That Apply)
Fever Productive cough Non-productive cough Severe Fatigue Bronchitis
Respiratory Infection Sore Throat Nausea Diarrhea
Initials: _____

It is recommended that any Patient experiencing any symptoms of Covid-19 do not receive treatment. Initials: _____

Massage Patient History & Financial Policy

If this is your first massage at South Cherokee Chiropractic, please fill out this form completely.

Name:_____ Cell #: _____
Address: _____ Home #: _____
City: _____ DOB: _____
State & Zip: _____

Occupation : _____ Email: _____
Emergency Contact Name: _____ Phone: _____

Whom may we thank for referring you? _____

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit Have you ever had a professional massage before? Yes / No

If yes, how often did you receive massage therapy? _____
Do you have any difficulty lying on the front, back, side? Yes / No
If yes, explain:_____
_____

Do you have any allergies to oils, lotions, or ointments? Yes / No
If yes, explain: _____
_____

Do you have sensitive skin? Yes / No

Are you wearing: Contact lenses ( ) Dentures ( ) Hearing aids ( )

Do you sit for longs hours at a workstation, computer or driving? Yes / No
If yes, explain:_____
_____

Do you perform any repetitive movement in your work, sports or hobby? Yes / No
If yes, explain:_____
_____

Do you experience stress in your work, family, or other aspect of your life? Yes / No
If yes, how do you think it has affected your health? _____
_____

Muscle tension ( ) Anxiety ( ) Insomnia ( ) Irritability ( ) Other:_____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes / No

If yes, please identify:_____

Do you have any particular goals in mind for this massage session? Yes / No
If yes, explain: _____
_____

Medical History:

In order to plan a massage session that is safe and effective, some general information about your medical history is needed.

Are you currently under medical supervision? Yes / No
If yes, explain:_____
Do you see a Chiropractor? Yes / No
If yes, how often: _____
Are you currently taking any medications? Yes / No
If yes, please list:_____
_____

Please check any condition listed below that applies to you:

( ) contagious skin conditions ( ) phlebitis
( ) open sore or wounds ( ) deep vein thrombosis/ blood clots
( ) easy bruising ( ) joint disorder/ rheumatoid arthritis/osteoarthritis
( ) recent accident or injury ( ) osteoporosis
( ) recent fracture ` ( ) epilepsy
( ) recent surgery ( ) headaches/migraines
( ) artificial joint ( ) cancer
( ) sprain/strains ( ) diabetes
( ) current fever ( ) decreased sensations
( ) swollen glands ( ) back/neck problems
( ) allergies/sensitivities ( ) fibromyalgia

( ) heart conditions ( ) TMJ
( ) high or low blood pressure ( ) carpal tunnel syndrome
( ) circulatory disorder ( ) tennis elbow
( ) varicose veins ( ) pregnancy (If yes, how far along?)
( ) atherosclerosis

Please explain any condition that you have marked above: _____

- _____

- _____

Is there anything else about your medical history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

Draping will be used during this session – only the area being worked on will be uncovered.

I, (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/ or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Financial Policy: I understand that a fee of $25 will be charged if I "NO SHOW" for and appointment. If I am late for an appointment, my session will be shortened, but I will still be responsible for the full time that I was scheduled for. I will call in a timely manner if I cannot keep my appointment. I may request a super-bill to submit to my insurance. Payment is due at the time of services are rendered. We accept cash, check, and all major credit cards.

Signature of Client:_____ **Date** : _____

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by parent or legal guardian of any client under the age of 17.

Minor Informed Consent

I, (print name), hereby give my permission (and until further notice) to

(Massage Therapist) to provide my minor/child under my guardianship with therapeutic massage services as deemed appropriate to treat presenting conditions/injuries. I understand that I am financially responsible for the minor, and that all statements contained in this consent apply equally to myself and to the minor.

Signature of Parent/Legal Guardian of Client:_____ **Date**: _____

My child/charge has my permission to appear for treatment without me present and I further understand that I must make the appointments.

Signature of Parent/Legal Guardian of Client: _____ **Date**:_____

4796 Canton Rd. Marietta, GA. 30066
Phone: 770-926-9488
office@southcherokeechiropractic.com
www.southcherokeechiro.com

Submitting Massage Claims to Insurance

Submitting any claims to insurance, especially those related to massage therapy, is not a guarantee of payment. We will file your claims as a courtesy, although you are responsible for the entire balance. New and past issues have resulted in stricter office polices regarding our submission and collection on massage therapy charges. Please read carefully as these policies will be upheld and referred to if issues arise.

Office Policies

· The patient first needs to contact the insurance company in question to inquire about massage therapy coverage. Please give them the CPT code **97124** as this is the **ONLY** way we will code massage. They also need to be informed that services will be performed by a **licensed massage therapist**.

· In our contracts with our massage therapists; we are obligated to receive **NO LESS** than our cash prices (stated below) for their services. This means that regardless of what the EOB shows in the patient responsibility section, you will be responsible for payment to achieve our minimum requirements to pay our therapists. This is non-negotiable and issues with the patient or insurance company will result in termination of our submission courtesy.

· Until we receive an EOB confirming payment, the patient will be responsible for paying the full cash price up front. Cash prices are as follows:

30 minutes = $40
60 minutes = $75
90 minutes = $105

· Please note, one payment from insurance does not guarantee continued payment or a reversal of the claim, we will only offer office credit or reimbursement on the service that the claim paid for. Meaning, we will continue to monitor payments and update your patient ledger as we receive payments.

· We reserve the right to refuse, or at any time, terminate this courtesy.

BY SIGNING BELOW, YOU ACKNOWLEDGE AND AGREE TO THE TERMS AND CONDITIONS LISTED ABOVE.

_____ _____

Patient Signature & Date Witness Signature & Date