Name: _____ Date: ____/____/_____

Alivio Therapeutic Massage 600 W. 41 St. 202 A Anchorage, Alaska 99503 (907) 441-2994

Name_____ Date: _____/_____/_____
(First) (Last)

DOB:_____/_____/_____ Social Security: _____-_____-_____

Primary Phone:_(_____)_____-_____ Email:_____

Address:_____ City:_____ ST:_____

Insurance Claim? Y / N Insurance Provider:_____ Workman's Comp / Personal Claim Injury
Claim Agent: _____ Agent Number: (_____) _____-_____
Claim #:_____ *Benefits need to be verified with Alivio Therapeutic Massage prior to your first appointment.

How did you hear about us?_____
How often do you receive body work?_____
Where have you been treated?_____
Name of current physician?_____
What is your preferred type of music?_____

Please check all of the following areas that cause pain or discomfort.

- ❒ Bending Forward / Backward
- ❒ Lying on Back / Side / Stomach
- ❒ Pulling / Pushing / Reaching
- ❒ Running / Walking
- ❒ Sitting / Standing
- ❒ Turning Head / Back
- ❒ Kneeling ❒ Lifting
- ❒ Sports ❒ Twisting ❒ Working

What are you chief complaints?_____

_____

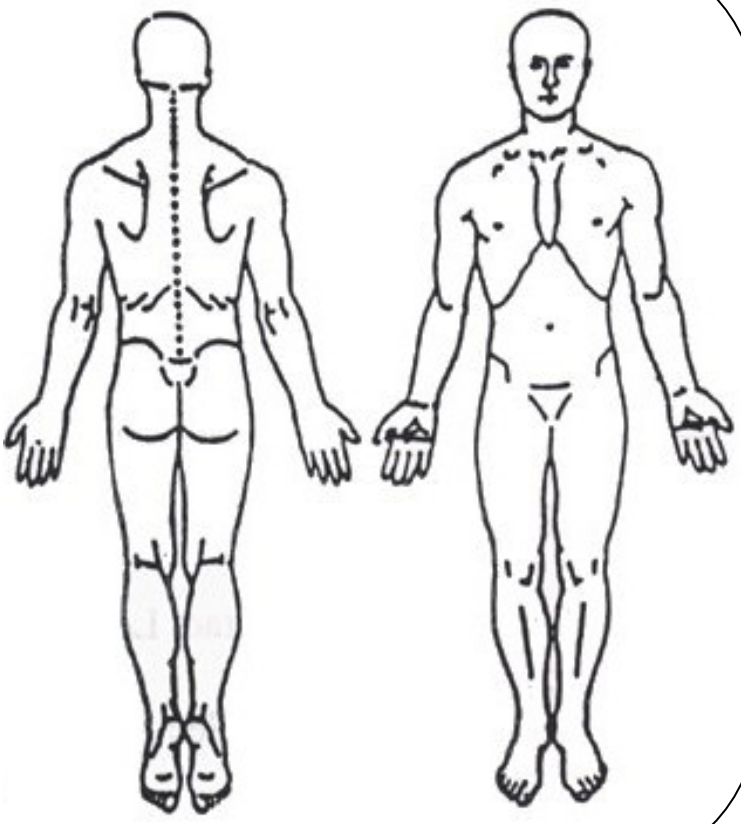
_____

What are you hoping to achieve from today's session?

_____

_____

_____



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Please check all of the following that you have or had.

- ❒ Anemia
- ❒ Arthritis
- ❒ Artificial Bones / Joints
- ❒ Asthma / Difficulty Breathing
- ❒ Cancer
- ❒ Chemotherapy
- ❒ Congenial Heart Defect
- ❒ Disc Herniation _____
- ❒ Eczema
- ❒ Fainting / Seizures / Epilepsy
- ❒ Fibromyalgia
- ❒ Frequent / Severe Headaches
- ❒ Heart Surgery / Pacemaker
- ❒ Hepatitis
- ❒ Herpes
- ❒ High / Low Blood Pressure
- ❒ HIV+ / AIDS
- ❒ Kidney Problems
- ❒ Lower Back Pain
- ❒ Lupus
- ❒ Psychiatric Problems
- ❒ Rheumatic Fever
- ❒ Scoliosis
- ❒ Shingles
- ❒ Sinus Problems
- ❒ Stroke

❒ Other Serious Conditions _____

HIPAA Privacy Policy

Alivio Therapeutic adheres to the HIPAA rules and regulations while striving to maintain private patient information. The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

Permitted Uses and Disclosure:

We only disclose your information to approved medical and insurance personal in order to serve your treatment, payment or health care operation needs.

Entities recognized by law may use and disclose protected health information without individual authorization as required by law (including by OCR Privacy Rule Summary 7 Last Revised 05/03 statute, regulation, or court orders)

If you agree to this policy please sign this document. Further information regarding the HIPAA policy can be given upon request.

Signature _____ Date: _____

Emergency Contact

Name:_____ Phone Number: (_____) _____- _____

Company Policy

Alivio Therapeutic Massage believes in maintaining an atmosphere of professionalism and respect. Staff and clients are to adhere to the same beliefs while within these walls. Any inappropriate behavior will result in the immediate end of your session.

Appointment Policy

If you are unable to keep you appointment, a minimum of 24 hours notice is necessary or you will be charged for a missed appointment.

Billing Policy

Payment is expected in full at time of your appointment unless you are submitting a health insurance, worker's compensation or personal injury claim. It is recommended to contact your insurance provider to check for your entitled benefits. If a claim is to be filed on your behalf, the insurance provider is expected to submit payment within 60 days. Any denial in charges from a claim will become the responsibility of the patient. Please note we are not liable for changes in your insurance provider's policy or denial of service. Payment must be made to Alivio Therapeutic Massage immediately if other coverage has not been paid.

Printed Name:_____

Signature:_____ Date: _____/_____/_____