Russo Neuromuscular Massage Center

1145 Reservoir Avenue Suite 210, Cranston, RI 02920

Motor Vehicle Accident or Workers' Compensation Medical Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

DOB: _____ Phone (Circle one: cell, home, work): _____

Emergency Contact/Relation: _____ Phone: _____

Occupation: _____ Referred by: _____

Employer: _____

Have you received massage therapy in the past? _____ If yes, which type? (Swedish, Deep Tissue, Neuromuscular Therapy, Sports, Other?_____

INSURANCE INFORMATION:

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Was the injury the result of an accident?_____ If yes: Job related:_____ Auto_____ Other _____

Date of Injury: _____

INSURANCE COMPANY:

Name: _____

Billing Address: _____

Phone Number: _____

Contact Person/Case Manager: _____

ATTORNEY (if applicable):

Name: _____

Address: _____

Phone: _____

ACCIDENT INFORMATION:

Date of Accident: _____/ _____/ _____

Your Vehicle: Year_____ Make _____ Model _____

Other Vehicle: Year_____ Make _____ Model _____

Circle All that Apply:

Was this injury accident related: Yes / No Auto Work Other

Was this a Job or Work related injury: Yes / No Were you: Driver / Passenger

Were you wearing a seatbelt? Yes / No Did the airbag deploy? Yes / No

Impending Collision, were you: Aware / Unaware / Braced / Not braced

Did your head: Strike Object / Not Strike Object

Did you experience: Shock / Loss of Consciousness / Whiplash / Other

Describe the events off the injury or accident: _____

_____

_____

_____

_____

_____

IMMEDIATELY FOLLOWING THE ACCIDENT:

_____ Ambulance/Rescue called

_____Transported to Hospital by Rescue

_____Diagnosed at Hospital

_____Medication prescribed

_____ Treated at the scene & released

_____ Went to Hospital on my own

_____ Treated at the Hospital

_____ Follow-up recommended

_____ _____

List the Diagnostic Tests that have been performed for this problem:

X-Rays / C T Scan / M R I Scan / E M G Scan

List the treatments you have had for this problem:

____ Ice pack ____ Heat pack _____ Bed Rest _____ Brace ____ Ultrasound

____ Electrical Stimulation _____Injections _____Accupuncture ____ Physical Therapy

SYMPTOMATOLOGY:

Circle the symptoms your are experiencing:

Pain - Dull / Sharp / Radiating

Numbness / Tingling / Burning / Electrical

Stiffness / Limited Range of Motion (ROM)

PAIN RATING:

On a scale of 0 – 10, rate your pain: (Please circle)

No Pain Severe Pain

0 1 2 3 4 5 6 7 8 9 10

Describe severity of pain:

_____Mild Nuisance _____Mild to Moderate, but can live with it

_____Moderate, having trouble coping with it _____ Severe, it is ruining my quality of life

Pain is:

____Constant _____Comes & Goes

_____Onset with certain activities or movements

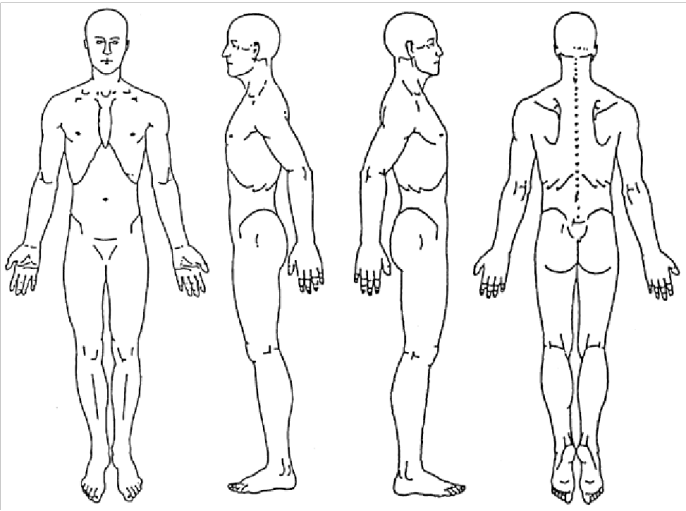
What activities or movements are limited or trigger symptoms:_____

_____

How often do you have to stop activities to sit or lie down to control your symptoms: (Please Circle)

Several times / Occasionally / Approximately ____ times per day / Never / All Day

Please mark the areas where you are experiencing your symptoms:



List activities and movements that trigger the symptoms:

List activities & movements that help relieve symptoms:

List past surgeries &hospitalizations:

List previous back, neck and musculoskeletal problems:

List health conditions & diseases:

Are you pregnant? (Y or N) If yes, how many weeks? _____

Do you have any allergies? (Seasonal, environmental, food, and/or medications): _____

List all medications you are taking, including over-the-counter items and vitamins:

Informed Consent

I have completed this health intake form accurately and to the best of my knowledge. I understand the treatment here is not a replacement for medical care and the therapist/practitioner does not prescribe medical treatment. I understand that the treatment is not a substitute for medical treatments and/or diagnosis, and it is recommended that I see a qualified professional for any physical or mental conditions I may have. I agree to inform the therapist of any health changes including medications and recommendations made to me by my medical physician or other health care professional. I agree to keep the therapist up to date with any injury/accident occurrences. I give my consent to receive massage therapy and agree to inform the therapist if I have any discomfort or pain during or after the treatment and will consult on any questions or concerns I have immediately. I enter into treatment in good faith, realizing that as a licensed massage therapist, the therapist will practice within the guidelines set down by their professional training and the State of Rhode Island.

I understand that payment is due at the time of treatment unless previous arrangements have been made.

I agree to provide at least a **24-hour** notice to cancel or change an appointment. If I fail to do so, I agree to pay the **full** session fee.

Signature _____ Date_____

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Medical Reports and Financial Lien

I do hereby authorize _____ to
Furnish my attorney with a full report of the examination, treatment, prognosis, etc., on myself in regard to the accident/injury in question.

I hereby authorize and direct you as my attorney to pay said therapist:
_____directly such sums as may be due and owed them for medical services rendered to me by reason of the accident in question and also to withhold such sums from any settlement, judgement, worker's compensation benefits, or verdict which may be paid to you, my attorney, or myself, as a result of the injuries for which I have been treated or injuries in connection therewith.

I agree to never rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that, in the event that another attorney is substituted in this matter, the new attorney will honor this lien as inherent to the settlement, judgement, or verdict, by which I may eventually recover said fee.

I have been advised that if my attorney does not wish to cooperate in protecting the therapist's interest, the therapist will not await payment, but will require me to make payments on an ongoing basis.

I understand that I remain personally responsible for the total amount due regardless of the result of a successful or unsuccessful settlement. For I authorize Russo Neuromuscular Massage Center to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate the collection under this Agreement, Lien and Authorization.

Please acknowledge this lien by signing and returning to our office.

Patient's name (Please Print) _____

Patient's signature: _____ Date: _____

The undersigned, being attorney of record for the above named patient, does hereby agree to observe all the terms of the above lien and agrees to withhold such sum from any settlement, judgement or verdict as may be necessary to adequately protect the above named therapist.

Attorney's signature: Date:

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Our Policy Regarding Payment for Motor Vehicle Accidents, Workmen's Compensation Claims, and Personal Injury Claims

So that we may preserve the best possible relationship with our patients, we hope that the following explanation of our position with Insurance Carriers and settlement payments will be helpful.

1. The proper relationship between the patients, therapists, and insurance carrier is often misunderstood. We render to you our very best care and charge you for that service. Just as the insurance companies do not allow us to set their premium rates, we cannot allow them to set our fees or determine which therapies are best for you. These fees are mutually agreed upon between you and us, and the insurance carrier does not enter into the relationship.

2. Insurance company policies vary in the amount that will be paid towards any charges. **Please be aware that there <u>may</u> be balances due after your insurance has made its payment, <u>which will be your responsibility.</u>** We will bill you for these balances, and expect prompt payment.

3. Our services are rendered to you, not the insurance company. **<u>You have final responsibility to see that all services are paid.</u>**

4. **<u>I understand that I remain personally responsible for the total amounts due regardless of the result of a successful or unsuccessful settlement.</u>**

5. It is your responsibility to call your insurance company or attorney with any questions regarding coverage, including obtaining referrals.

Should I not pay the balance due within thirty (30) days, I understand that I will be charged interest at 18% annually on my unpaid balance. I further understand and agree that should any unpaid balance be placed with an attorney for collection, I will be held responsible for attorney fees in the amount of 33⅓ % of the balance then due.

I understand and agree to the above statements. I also authorize payment of medical benefits to Therapist / Russo Neuromuscular Massage Center for services provided to me or any member of my family covered under my insurance policy.

I authorize the release of any medical or other information to process my claim promptly.

Signature: _____ Date:_____