LoTurco Chiropractic PLLC

Massage Intake form

Name:_____ Date:_____ DOB:_____

Phone:_____ E-mail:_____

Street Address:_____ Apt:_____

City:_____ State:_____ Zip:_____

Emergency Contact:_____ Relation:_____

Emergency Contact Phone:_____

Have you had a massage? **Y / N** If so, did you enjoy it? **Y / N**

Are you Pregnant? **Y / N** If so, how many months? _____

Please tell us the purpose of this massage: _____

What questions, concerns, or special needs do have?

_____

_____

_____

Would you like a FREE Chiropractic Examination and Consultation (adjustment not included)? **Y / N**

Please check all that apply:

Allergies	Heart Disease	Varicose Veins
Cancer	Hepatitis	High Blood Pressure
Diabetes	Herpes	Multiple Sclerosis
Epilepsy	Seizures	Pace Maker
Fibromyalgia	Stroke	Other:

Medications?_____

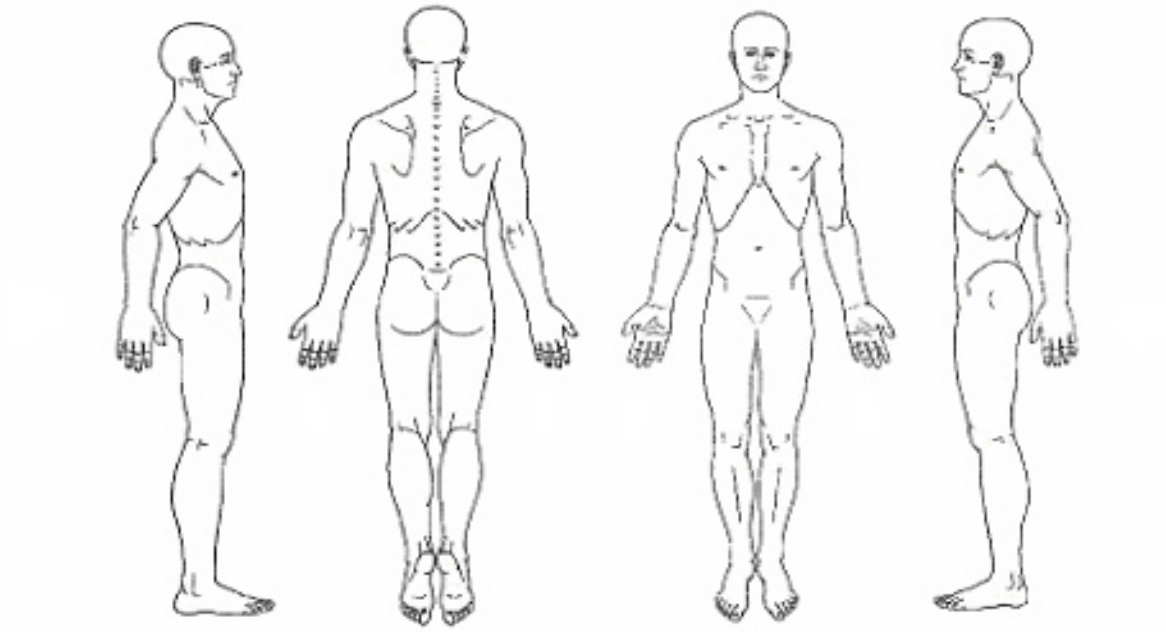
_____

_____

Surgeries?_____

_____

Please mark ALL areas of pain or discomfort:



Given the strict adherence to massage therapy being a nonsexual service, clients may remove all or part of their clothing (depending on their comfort level) to improve the therapeutic value of the massage. If you have any questions or concerns about this topic, please discuss these concerns with your massage therapist. If you have a specific medical condition or specific symptoms, massage may be contraindicated. A referral may be required prior to service being provided. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should consult a physician, chiropractor, or other qualified specialist for any suspected ailments. I understand that nothing said during the session should be construed as diagnosis or prescription. Because massage should not 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 practitioner updated as to any changes and understand that there shall be no liability on the practitioner's part should I forget to do so. I also understand that all information provided on this form or given verbally while in session is strictly confidential other than as required for insurance billing purposes or required by law. Any other release of this information cannot be granted without consent.

Cancellations require 24-hour notice. THERE IS A $20.00 FEE OTHERWISE

By signing below, I acknowledge that I fully understand and agree to the above information.

Signature: _____ Date: _____

Print Name:_____

LoTurco Chiropractic PLLC

255 Union blvd Suite 330
Lakewood, CO 80228
720-476-5121
www.loturcochiropracticgroup.com

Notice of Privacy Practices and Patient Rights

The use and Disclosure of Protected Health Information
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.

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect right now, but we reserve the right to change the terms. If there is a change, we will provide you with a written, revised notice upon request.

As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment and health care operations. These uses and disclosures require your consent, and include, but are not limited to the following information:

- A release of information contained in financial and/or medical records;
- Diseases spread person to person, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- Drug and/or alcohol abuse;
- Psychiatric diagnosis and treatment records;
- Laboratory test results;
- Medical history;
- Treatment progress;
- Data from the OASIS data set (home health);
- Any other related facts.

We may release the above to:

1. Your insurance company, Medicare, Medicaid, or any other person who will pay your bill for services or who will process your bill for services in order for us to receive payment;
2. Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors and state Risk Management;
- Any hospital, nursing home, or other health care facility where you may have done testing done or to which you may be admitted;
- Any assisted living or personal care facility where you live;
- Any doctor providing your care;
- Family members and other people who are part of your plan for service, in such programs as CSHP, EPSDT, home health, hospice, etc.;
- State and/or Federal agencies acting on behalf of programs, Medicare and/or Medicaid, including state surveyors or auditors for programs such as CSHP, EPSDT, PCS, WIC, STD/HIV, home health, hospice, etc.;
- Other health care people to start treatment.

We may contact you to:

1. Provide appointment reminders or news about other health programs we provide;
2. Raise funds or donate items for our business.

We are allowed to use or disclose facts about you without consent in the following situations:

1. In emergency treatment situations, if we try to obtain consent as soon as possible after treatment;
2. Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation;
3. Where we are required by law to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure is required by law;
5. For certain public health activities, such as reporting births, deaths, injuries, diseases, etc.;

LoTurco Chiropractic PLLC

255 Union blvd Suite 330
Lakewood, CO 80228
720-476-5121
www.loturcochiropracticgroup.com

6. Where we reasonably believe you are a victim of abuse, neglect, or domestic violence to a government agency authorized to received abuse, neglect or domestic violence reports;
7. Health care oversight activities;
8. Certain legal administrative proceedings;
9. Certain law enforcement purposes;
10. To coroners, medical examiners and funeral directors in certain situations (home health, hospice, etc);
11. For organ, eye or tissue donation purposes (home health, hospice, etc.);
12. For certain research purposes;
13. To avoid a serous threat to health and safety;
14. For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutional and custodial situations;
15. For Worker's Compensation purposes.

We are allowed to use or disclose facts about you without consent or authorization provided you are informed in advance and given the chance to agree to, restrict or forbid the disclosure in the following situations:

1. The use of a directory of people served by us (clinic schedules, patients schedules);
2. To a family member, friend or other person you choose who may assist in your care or payment for care.

Other uses and disclosure will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

Patient Rights:

You have the right, subject to certain conditions, to:

1. Request restrictions on certain uses and disclosures of facts about you by filling out our Request form. However, we are not required to agree to the request restrictions.
2. Receive confidential communication of protected health data by giving us another address or means of receiving health data.
3. Inspect and copy protected health data by filling out our request form.
4. Amend protected health data by filling out our form.
5. Receive a list of disclosures made of your protected health data by filling out our request form.
6. Obtain a paper copy of this notice upon request, if you agreed to this notice by e-mail, fax, or website.

Complaints

You may complain to us and the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must state the specific incident(s) including the date, what happened and details of the incident.

By signing below, you are stating you understand and agree to all the above statements.

Print Name

Signature

Date