Luminous Roots

Insurance Form

Name: _____ Date: _____

Best Phone Number: _____ Date of Birth: _____

Social Security Number: _____

Private Health Information

Name of the Insured: _____ Insurance ID: _____
alpha prefix

Insurance Name: _____ Group Number: _____

Insurance Address: _____ State: _____ Zip: _____

Insurance Phone: _____ This is my **primary** **secondary** insurance. (circle one)

Insured's Address: _____ State: _____ Zip: _____

Insured's Phone: _____ Insured's Date of Birth: _____

Insured's SSN # _____ Insured's Employer or School: _____

Worker's Compensation – L & I

Claim #: _____ Adjuster's name: _____

Date of Injury: _____ Employer: _____ Phone: _____

Attending Physician: _____ Phone: _____

May I have your permission to consult with this physician regarding this claim? ☐ Yes ☐ No

Have you had any massages for this injury? ☐ Yes ☐ No

Insurance Form (cont'd)

Personal Injury – Automobile Information

Was this accident determined to be your fault? Yes ☐ No ☐ Date of Injury: _____

Driver's Insurance Company: _____ Name of the Insured: _____

Insurance Address: _____ State: _____ Zip: _____

Claim#: _____ Adjuster's Name:_____ Phone: _____

At Fault Insurance Company: _____ Name of the Insured: _____

Insurance Address: _____ State: _____ Zip: _____

Claim#: _____ Adjuster's Name:_____ Phone: _____

Attorney's Name: _____ Phone: _____

Not Using Insurance – Payment at time of service

Initials _____

All clients must read and sign below:

In fairness to the other clients and me, 24-hour notice is required for cancellation of an appointment, or you will be charged in full for the time booked.

Once your insurance coverage has been verified, Luminous Roots will be glad to bill directly to and accept payment from the insurance company. It should be understood that all services are charged to you, the client, who is legally responsible for payment. Client agrees to pay all collection costs including but not limited to reasonable attorney fees, late charges and litigation costs in the event of any breach, including failure to timely make any required payments.

I hereby authorize the release of my medical records to the above insurance company for the express purpose of payment for my medical bills incurred with Luminous Roots.

I hereby authorize the insurance company or attorney to remit payment directly to this office.

Signature _____ Date _____

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Massage Health Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Gender: _____

Email: _____ SSN: _____

Best Phone Number: _____ Date of Birth: _____

Emergency Contact: _____ Referred by: _____

Health History

Are you currently seeing a medical practitioner? Yes No If yes, please explain below.

_____

_____

_____

Referring Health Provider: _____ Phone Number: _____

May I have your permission to consult with the providers you've named above?	☐ Yes _____ (please initial) ☐ No

Have you had any surgeries/accidents in the last seven years? No☐ Yes☐ If yes, please list below.

_____

_____

_____

What brings you in today? _____

Are you currently taking any medications and/or supplements? No☐ Yes☐ If yes, please list below. Be sure to include any pain relievers like ibuprofen, aspirin, etc.

_____

_____

_____

For the section below, please note if you have any of the following conditions. Please mark **Past** or **Current.**

Musculo-Skeletal

- ☐☐ bone or joint disease
- ☐☐ tendonitis
- ☐☐ bursitis
- ☐☐ broken/ fractured bones
- ☐☐ arthritis
- ☐☐ sprains/strains
- ☐☐ low back, hip, leg pain
- ☐☐ neck, shoulder, arm pain
- ☐☐ headaches/head injuries
- ☐☐ spasm/cramping
- ☐☐ jaw pain

Other _____

Circulatory

- ☐☐ heart condition
- ☐☐ varicose veins
- ☐☐ blood clots
- ☐☐ high/low blood pressure
- ☐☐ lymph edema

Digestive

- ☐☐ constipation
- ☐☐ gas/bloating
- ☐☐ diverticulitis
- ☐☐ irritable bowl

Other _____

Nervous System

- ☐☐ herpes/shingles
- ☐☐ numbness/tingling
- ☐☐ chronic pain
- ☐☐ fatigue
- ☐☐ sleep disorder
- ☐☐ neuritis/neuralgia
- ☐☐ sciatica
- ☐☐ memory loss

Reproductive

- ☐☐ pregnant - ____ weeks
- ☐☐ PMS

Other _____

Respiratory

- ☐☐ asthma
- ☐☐ lung disease
- ☐☐ sleep apnea
- ☐☐ difficulty breathing

Other _____

Life Experiences

- ☐☐ cancer/tumors
- ☐☐ diabetes
- ☐☐ eating disorder
- ☐☐ HIV positive
- ☐☐ anxiety
- ☐☐ nervousness
- ☐☐ grief
- ☐☐ drug/alcohol addiction
- ☐☐ more

Allergies/Intolerance

- ☐☐ Skin Rashes
- ☐☐ Hay Fever

Other _____

Signature _____ Date _____

Luminous Roots

Informed Consent for Breast & Pelvic Massage

I, _____, am voluntarily wishing to experience a session(s) of therapeutic massage, which may target breast and pelvic regions, performed by Cypress Mendoza.

I understand that massage therapists do not diagnose illness, prescribe medications or make spinal adjustments. I further understand that massage is not substitute for medical care or treatment for cancer or other illnesses.

I have alerted my therapist to any conditions I have which may affect the work and have disclosed all medications (herbal or pharmaceutical) that I am currently taking. I further agree to update my practitioner to any changes in my mental, emotional, or physical health.

I am seeking therapeutic massage of my own accord for the purposes that breast and pelvic massage is intended. Such purposes include, but are not limited to, injury treatment, relaxation, mental wellness, improved circulation, and/or improved range of motion.

I understand and have had explained to me the procedure of therapeutic massage, as it relates to breast and pelvic regions, the benefits and contraindications for massage and the side-effects which may occur as a result of massage.

Please read & initial the three statements below in boxes provided:

	I understand that I may stop the session anytime during the current session.
	I understand that I may request—now and in the future—a witness present in the room for my comfort and safety.
	I have read this consent and it has also been explained to me verbally

Name of Client (please print): _____

Client's signature: _____ **Date:** _____

Optional:

Name(s) of Witness(es) Present (please print): _____

Signature(s) of Witness(es) Present: _____ Date: _____