9061 E Frontage Rd
Palmer, Alaska 99645

Recovery Waters
PHYSICAL THERAPY

Phone: 907-331-6992
Fax: 907-802-6559

Massage Intake

Patient Information	
Name:_____	Gender: _____
Address: _____	Date of Birth: _____
City, State, Zip Code:_____	Cell Phone: _____
Email: _____	Home Phone: _____

Emergency Contact	
Name:	Phone:

How would you like to receive appointment reminders? – CHOSE ONE

☐ Text Cell ☐ Call Cell ☐ Call Home ☐ Email ☐ No reminders

Medical History

☐ Diabetes (type): _____	☐ Epilepsy/Seizures	☐ Scoliosis	☐ Osteoporosis
☐ High Blood Pressure	☐ Hard of hearing	☐ Parkinson's Disease	☐ Osteoarthritis
☐ Low Blood Pressure	☐ Hepatitis	☐ Multiple Sclerosis	☐ Rheumatoid Arthritis
☐ **Congestive Heart Failure/cardiac edema**	☐ Liver disease	☐ Traumatic Brain Injury	☐ Fibromyalgia
☐ **Kidney Failure**	☐ HIV/AIDS	☐ Stroke/TIA	☐ Altered sensation
☐ **Severe arteriosclerosis (ABI 0.49 or less)**	☐ Asthma	☐ Dementia/Alzheimer's	☐ Wound(s)
☐ Heart Attack	☐ COPD	☐ Asperger's/Autism	☐ Adhesive Allergy
☐ Varicose veins	☐ Cellulitis	☐ Skin Disorder	☐ Latex Allergy
☐ Venous Insufficiency	☐ Active infection	☐ Blood Clots	☐ Cancer
☐ Auto-immune disease	☐ Abdominal aortic aneurysm	☐ EDS	☐ Other: _____
☐ Migraines	☐ Bruise easily	☐ Currently Pregnant	_____
☐ Back pain	☐ Hypothyroidism	☐ Currently Breast Feeding	_____
	☐ Hyperthyroidism	☐ Dizziness/Fainting	_____
		☐ Psychiatric Disorders	

Recent Surgeries and Dates (Last 3 years)	

Consent to Treat

I agree and consent to assessment and treatment. I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: _____ Date: _____

Relationship to Patient: _____

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Cancellation and No-Show Policy & Credit Card on File

The **cancellation and no-show policy** have been established in order to provide the highest level of service to all our patients. It has been proven that consistent attendance provides the greatest opportunity for success. By providing us with notice of a cancellation, we may be able to accommodate other patients with your appointment slot.

- Patients must call at least 24 hours prior to their scheduled time, when they knowingly are unable to make their appointment. Cancellations within 24 hours of appointment will be considered a late cancellation.
- **There is a $50 no-show and/or late cancellation fee. Payable through your credit card on file.**
- **After two (2) no shows/late cancellations within a 60-day period, the patient will be able to schedule same day appointments only.**
- Patients will be provided copies of their scheduled appointments and given appointment reminders by their choice of email, phone, or text.

At Recovery Waters Physical Therapy, we require **a credit or debit card to be on file** for your convenience. This is to pay for the portion of services that your insurance does not cover, but for which you are liable. Your card will only be charged after notifying you.

Your credit card information is kept confidential and secure.

Credit Card Information

Name:_____ CVV:_____

_____-_____-_____-_____ Exp:____/____ Zip_____

I, the undersigned, authorize and request Recovery Waters Physical Therapy LLC to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility and any cancelled appointments not received before 24 hours of the scheduled visit.

Patient Signature _____

Print Name_____ Date_____

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Massage Intake - Insurance

Patient Information	
Name:	Date of Birth:

Primary Insurance	Secondary Insurance
Insurance Name: _____	Insurance Name: _____
Policy/ID #:_____	Policy/ID #:_____
Policy Holder's Name:_____	Policy Holder's Name:_____
Policy's Holder's Date of Birth: _____	Policy's Holder's Date of Birth: _____
Policy Holder's Phone Number: _____	Policy Holder's Phone Number: _____
Relationship to Patient: _____	Relationship to Patient: _____

INSURANCE NOTIFICATION

Services provided by Recovery Waters Physical Therapy are payable at the time of service. Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company, and although we may estimate what your insurance company might pay, it is the insurance company that makes the final determination of payments made on your behalf.

If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. This means it is your responsibility to know the limitations associated with your insurance policy. Failure to obtain the referral and/or preauthorization may result in a lower payment or no payment from your insurance company. It is also your responsibility to notify us if your insurance changes or terminates. You will be responsible for any unpaid services. If you have additional questions, you will need to speak to someone prior to your appointment or contact your insurance company directly for all specific plan benefit information.

By signing below, I am acknowledging that I have read, understood, and agree to the Insurance Notification.

_____ _____

Signature Patient/Guardian Date