NATURAL Health Works

PERSONAL AND INSURANCE INFORMATION

Please write legibly.

Name ____

Last First Middle

Address ____

City ________________________________ State____________ Zip Code ______________

Home Phone # _________________________ Cell Phone # ___________________________

Employer ____________________________ Work Phone # ___________________________

Email Address ____ Marital Status M D S W

Date of Birth _____/_____/_____ Primary Care Physician _______________________________

Emergency Contact ______________________________ Phone #_____________________

Related to a Motor Vehicle Accident: Yes ________ No ________ Date of Injury: ______________

Related to a Workers Compensation: Yes ________ No _______ Date of Injury: ______________

Primary Insurance ____

Policy # ______________________________________ Group # ________________________

Guarantor (who insurance is through) ____

Relation ____________________________________ Guarantor Date of birth_____/____/_____

Guarantor Address ____

City ________________________________ State______________ Zip Code ______________

Guarantor's Employer ____

Secondary Insurance ____

Policy # ______________________________________ Group # ________________________

Guarantor (who insurance is through) ____

Relation ____________________________________ Guarantor Date of birth_____/____/_____

Guarantor's Employer ____

710 John Adams St. | Oregon City, OR 97045 | T (503) 722-7776 | F (503) 723-0789 | info@naturalhw.com | www.NaturalHW.com

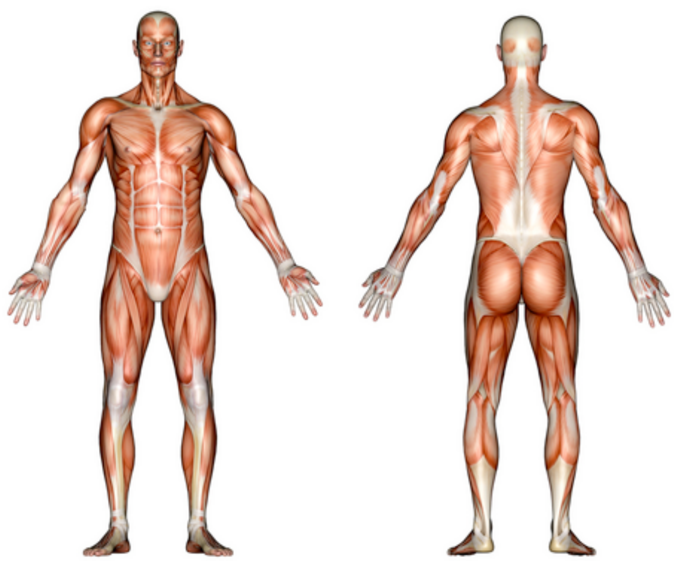
NATURAL Health Works

Massage Therapy Health History

Name: ____ Date: ____________________________

Primary reason for appointment:____

Using the figures below please circle the areas you are having trouble with, or areas of pain, stress, tension, or tightness.



Please mark an X on all conditions for current or past that apply.

Conditions	**Current**	**Past**	**Conditions**	**Current**	**Past**	**Condition**	**Current**	**Past**
Headache			Head/Neck Injury			Arthritis/Tendonitis		
Varicose Veins			Back Injury			Cancer/Tumors		
Diabetes			Muscle/Bone Injury			Blood Clots		
Pregnancy			Sprains/Strains			Numbness/Tingling		
Rash			Jaw Pain/TMJ			Infectious Disease		
Fatigue			Chronic Pain			High/Low Blood Pressure		

Accidents:____

Surgeries:____

Medications:____

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Welcome to Natural Health Works, PC!

We are pleased that you have chosen us at Natural Health Works, PC. Our philosophy is to empower you to actively participate in your own healing. Our treatments use a holistic approach. It is important to us to know when you have ongoing health concerns, even when they are managed by another provider. Please keep us updated in any other health concerns you may be dealing with as well as any supplements and medications you may be taking. We believe that communication with our patients allows us to provide the best possible service to you. I authorize Natural Health Works, PC and their providers to treat me for medical conditions.

Insurance:

Physicians, patients and insurance carriers enter into a 3-way relationship to provide medical care. We assume the responsibility for providing high quality medical care and, according to our contracts; we file insurance claims on your behalf. Your insurance carrier has the responsibility to pay claims promptly and accurately without undue delay. We count on you to know your insurance benefits, provide us with accurate filing information, and to be attentive to making sure that your insurance carrier is paying claims in a timely manner. I authorize the release of any medical or other information necessary to process claims. I authorize payment of medical benefits to Natural Health Works, PC.

Our Policies: *Please initial each line*

1.______**Payments**: Co-payments, deductibles, supplements, and all non-covered services including select laboratory testing must be paid for at the time of service.

2.______**Insurance**: As a courtesy to you, we will file your insurance claims for you. Any Insurance filed and not paid within 90 days will be billed to the patient and payment will be expected from the responsible party.

3. ______**Private Pay:** Payment in full at time of service will be given a discount in coordination with allowed insurance contract rates. No discount will be given to payment plans. Payment plans requires 20% paid at time of service with remaining balance paid in equal payments over the next 3 months with a valid credit card left on file. I agree that NHW can charge my credit card on the agreed upon date.

4. ______ **Tardiness/Cancellations/Missed Appointments:** Please plan to arrive to your appointment on time. Our goal is to have your appointment start on time. Please call if you are running late. We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other clients that could benefit from this treatment time. There may be a $50.00 charge for patients cancelling without appropriate notice. A $50.00 fee may be charged for missed appointments without 24 hour notice. We may be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these appointments are adversely affecting your treatment plan. Prolotherapy Appointments must be cancelled 48 hours prior to the appointment; cancellations within 24 hours will be assessed a $50.00 charge; missed or late cancellations will be assessed at the rate of the entire visit. After two such cancellations in a six-month period it will be necessary to pay in advance for your appointment.

5. ______ **Privacy Policy:** I have been offered and/or received a copy of Natural Health Works, PC privacy policy.

If you have any questions regarding Natural Health Works, PC policies please contact a staff member. You may find us on the web at www.NaturalHW.com

I have read and agree to abide by the policies of Natural Health Works, PC

______________________________ ________________________

Responsible Party Date