SAPTHERAPY
PHYSIOTHERAPY & ORTHOPEDIC MASSAGE
www.saptherapy.abmp.com

Patient Intake Form

Name:_____ Date:_____

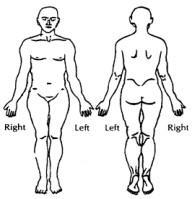
Date	**O Male O Female**	**DOB**	**Age**
Address		O Athlete	Sport
		Occupation	
Cell phone number		**Email**	

In order to better serve you, please provide us with the information below.
Please select or write any surgeries or condition diagnosed in the past five years: _____

- ☐ allergies
- ☐ diabetes
- ☐ low/high blood
- ☐ varicose Veins
- ☐ blood clots
- ☐ heart condition
- ☐ chest pain
- ☐ dizziness
- ☐ varicose Veins
- ☐ blood clots
- ☐ heart condition
- ☐ low back pain
- ☐ neck pain
- ☐ cancer
- ☐ arthritis
- ☐ herniated discs
- ☐ skin problems
- ☐ eczema
- ☐ HIV
- ☐ Sciatica
- ☐ shingles
- ☐ constipation
- ☐ psoriasis
- ☐ hepatitis

Please indicate areas of discomfort and/or pain

O Pain X Soreness



List any medications you are taking (prescription drugs, blood thinners (Aspirin), pain relievers):_____

Referring healthcare provider: _____ Phone: _____

Email: _____ Address: _____

24 hour advance notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment. **Packages or any discounted services aren't reimbursable. They can only be transfer or shared.**

Please provide a credit card that will be only in our record and applied in case of a NO SHOW or late cancelation.

Print name on the Card _____
Type: VISA Master Card Other:_____

CC No.__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __
Exp.___ /___
CVV __ __ __

Client/Guardian _____ Date _____

Licensed Therapist Signature _____ Date_____

HIPPA CONSENT FORM

For Use and disclosure of Protected Health Information (PHI) for Treatment, Payment or Healthcare Operation (TPO)

I understand as part of my healthcare, SapTherapy and ASAP Wellness Center will originate and maintain health records describing my medical history, symptoms, examination, test results, diagnosis, treatment and any plans for future care and treatment. I understand, also, this information serves as:

- A basis for planning my care and treatment;
- A means for communication among the many healthcare professionals who may contribute to my care;
- A source of information for applying my bill;
- A means by which a third payor can verify that services billed were actually provided; and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a NOTICE OF PRIVACY PRACTICES which provides a more complete description of information uses and disclosures. I understand I have the right to review this notice prior to signing this consent form. I, also understand that SapTherapy and ASAP Wellness Center reserves the right to change his privacy notice and practices.
With this consent, SapTherapy and associates may:

- Call my home or other designed location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or any other information pertaining to my care.
- Mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, patient statements, insurance items or any other correspondence as long as they are marked Personal and /or Confidential.
- Email to me appointment reminders, insurance items or other correspondence pertaining to my care.

By signing this form, I am consenting to SapTherapy full use and disclosure of my PHI to carry out his TPO.I may revoke my consent, in writing, except to the extent the practice has already made disclosures in reliance upon my prior consent. HIPPA form most be signed before treatment.

I, _____, understand that SapTherapy bodywork and assessments performed is with my absolute consent with awareness that certain physiological effects of orthopedic massage include circulatory enhancement and relief from muscular tension or discomfort. I understand that my therapist is not a physician and cannot diagnose or prescribe towards any medical condition or disease. I understand that it is my responsibility to notify my therapist of any changes in my health or medical history. I understand that it is ultimately my responsibility to notify my therapist if I am ever in any discomfort or pain. I hereby state that I have read the information above and have provided by SapTherapy with all notable information to the best of my knowledge. I give permission for the treatment that I am given and understand that is no substitute for any medication. I agree that neither I, my heirs, assigns or legal representatives will sue or make any claims of any kind whatsoever against SapTherapy/ASAP Wellness Center or its members for any personal injury, property damage/loss, or wrongful death, weather caused by negligence or otherwise.
Print Patient Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____ Date:_____