28162 HWY 57 Priest Lake, ID 83856 TEL: 208.946.1226 info@kivatherapeutics.com

Name: _____ Date:_____

Address: _____

City and State:_____Zip:_____

Phone: _____ DOB: _____ Occupation:_____

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Health History:

Why have you come for a massage? Do you want Light, Medium, or Deep Massage today?

Please list self-care routines, including stress reduction, exercise routine, and frequency:

Are you currently seeing a doctor? Onset date of Current Injury/Pain? Do you have any ongoing conditions? I.E. cardiovascular, endocrine, auto-immune, musculoskeletal disorders?

List current prescriptions, medications (include pain relievers, herbal remedies, and supplements):

Massage/bodywork should not be performed under certain medical conditions. In light of this, I affirm that I have stated all my known medical conditions and have answered all questions honestly and completely. I understand that there shall be no liability on the practitioner's part for the aggravation of conditions that were present, at the time of signing and which may be affected by the massage/bodywork session. Understanding that massage/bodywork is not a substitute for medical examination, diagnosis or treatment, I give my consent to receive massage/bodywork.

- **We appreciate you giving us 24 hours-notice of cancellation. Otherwise a $40 cancellation fee may apply.**

Patient/ Guardian Signature and Date:

Your Insurance Information

Only complete if you plan on using your insurance benefits to pay for massage therapy.

Please Bring your card to your first appointment. We will need to verify your information.

Type of Insurance: Auto _____ Health _____ L&I/Worker's Comp _____ PIP _____NA_____

Insurance Company _____

ID#_____ Group #_____ Phone #_____

PIP Claim # _____

Claims Adjuster _____ Phone # _____

Email Address _____

L&I/ Workman's Compensation Claim #_____

Claim Manager_____ Phone # _____

Email Address _____

Your Medical Team

Name of Referring Provider and Specialty:

_____

Phone # _____ Email Address_____

Clinic Address_____

Other Providers and Specialty:

_____

Patient Responsibility/Authorization of Release of Medical Benefits

- I (patient) agree to the release and use of my information for medical and/or insurance billing purposes and authorize Kiva Therapeutics LLC; to obtain any information from my healthcare providers concerning my health.
- I (patient) authorize payment of medical benefits to Kiva Therapeutics LLC and its' practitioners for Massage Therapy services.
- **I (patient) am aware, that I am fully responsible for all health care bills for services rendered regardless of determination by insurance company.**

Patient/ Guardian Signature and Date: