Taos Therapeutic Massage, LLC, 1332 Gusdorf Rd. Suite E, P.O. Box 1055, Taos, NM 8757 (575) 758-3868

Confidential Health Intake Form

Today's Date_____

Name_____Date of Birth_____

Street Address/Mailing Address_____

City_____State_____Zip_____Phone Number_____

Email_____ Please circle your preferred form of contact: phone text email

Emergency Contact/Relation_____ Ph#_____

Occupation/Employer_____

How did you hear of us? _____

If Self-Pay, your preferred method of payment: __Cash __Check __CC __Other __All/Any Listed

Please describe the main reason for your visit today and what you would like from your session:

_____

What movements or activities are limited, including sleep?_____

_____

Level of pain from 0 to 10, where & how often?_____

What seems to help the condition the most?_____

What seems to aggravate the condition the most? _____

What is your main activity at home or work? _____

Have you lost work from this condition (how many days)? _____

List physical activities you participate in regularly: _____

Have you experienced increased stress recently?_____

What do you do to relieve stress?_____

Describe injury, accident, or cause of this condition: _____

_____

List current medications/herbs/vitamins and dosage, esp. muscle relaxants, pain meds, anticoagulants:_____

_____

List diagnoses and treatments you have received for this, how often and from whom (doctor, acupuncture, physical therapy, chiropractor, naturopath, etc.) _____

_____

List previous major injuries/surgeries/complications/unusual diseases: _____

_____

List known allergies: _____

Please indicate for each of the questions below: 1. presently have or 2. previously had

Musculoskeletal System
___ low/middle/upper back pain
___ shoulder/rotator cuff issues
___ neck problems
___ arm/wrist/hand problems
___ leg/knee/ankle/foot problems
___ hip problems
___ stiffness
___ joint issues or pain
___ muscle pain
___ weak muscles
___ walking problems
___ sprains/strains
___ arthritis
___ broken bones
___ tendonitis
___ scoliosis
___ vertebra or disc problems

Nervous System
___ headaches
___ numbness/tingling
___ dizziness or fainting
___ muscle jerking
___ convulsions
___ confusion
___ fatigue
___ depression
___ anxiety
___ sleep difficulties

Skin
___ rashes, acne, warts, fungus
___ sunburn or inflammation
___ skin sensitivity
___ painful scars
___ allergies to lotion or oils

Reproductive System
___ endometriosis
___ menstrual pain
___ interruption in menstrual cycle
___ current pregnancy
___ prostate problems
___ pelvic pain

Gastrointestinal System
___ poor appetite
___ excessive hunger
___ excessive thirst
___ nausea
___ abdominal pain
___ diarrhea
___ constipation
___ liver or gall bladder trouble
___ weight trouble

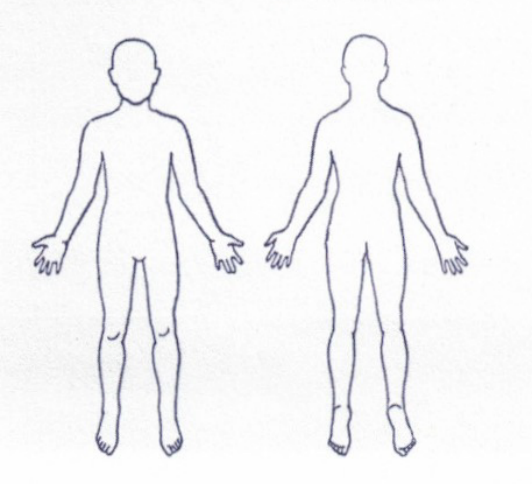
Eye, Ear, Nose & Throat
___ vision problems
___ eye pain or inflammation
___ ear pain
___ ear noise
___ hearing loss
___ sinus problems
___ difficult nose breathing
___ jaw pain/teeth grinding
___ difficulty chewing
___ difficulty swallowing
___ mouth, teeth, gum pain
___ hoarseness or speech difficulty
___ sore or swollen throat

Cardio-vascular System
___ varicose veins
___ high/low blood pressure
___ blood clots, thrombosis
___ aneurysm
___ chest pain
___ rapid heart beat
___ heart problems
___ difficulty breathing
___ persistent cough
___ lung problems

General
___ cancer/tumors
___ diabetes
___ osteoporosis
___ rheumatoid arthritis
___ auto immune disorder
___ heart disease
___ stroke
___ digestion issues
___ removed organs or lymph nodes
___ incontinence / frequent urges

Please mark your areas of pain on the figures below:

R Front L **L Back R**



Taos Therapeutic Massage, LLC ("TTM") LIC#MT3439

1332 Gusdorf Road, Suite E, P. O. Box 1055, Taos NM 87571 (575) 758-3868

Rates, Cancellation Policy, Records Release and Privacy Policy

Normal Rates: TTM uses the current FAIR Health cost of care list for our 87571 area, at www.FAIRHealthconsumer.org/. Modalities per 15 minute unit include CPT 97124 Massage Therapy $51, 97140 Manual Therapy $65, and 97112 Neuromuscular Reeducation $70. Current gross receipts tax (GRT) to be added. TTM fees are non-negotiable and subject to change without notice. *TTM accepts auto and other accident insurances on a case by case basis as well as Letters of Protection (LOP's) from reputable attorneys, at TTM's discretion. Accounts that carry balances for more than 30 days will be assessed an interest charge of 1% per month, compounded monthly. The massage client shall be liable for all administrative fees, legal fees and/or attorneys fees, costs and damages incurred by TTM pursuing unpaid bills, including collections efforts, Interpleader and/or other such actions.* ***LOP's are not and will not be discounted.***

Workmans Compensation Insurance Rates: TTM abides by the current WCA *State of New Mexico Health Care Provider Fee Schedule*. State and local gross receipts tax to be added.

Discounted Rates for Payment at Time of Session: Fees for sessions with Bonnie McNairn, LMT are $140 for 60 minutes and $210 for 90 minutes. This is an average discount of 58% from the Normal Rates. Fees with other LMT's may be different. GRT to be added. Fees are subject to change. *Includes all modalities within the therapist's ability and NM LMT scope of practice. These rates require payment at time of treatment and zero balance owed on account. We accept cash, check, credit & debit cards as payment. All debit & credit card transactions are subject to a 4% fee.* ***Gratuities are not expected yet gratefully accepted.***

I, _____(name of client) agree that should I cancel an appointment less than 24 hours before the scheduled time or "no-show" for an appointment, I am subject to a fee equal to the cost of the missed appointment. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee. Payment of this fee is due immediately and shall be paid before the next treatment session can be scheduled. If I arrive late, I understand the session will still end at the originally scheduled time and payment in full is due. *Please note: Insurance companies WILL NOT pay for missed appointments, this is the client's financial responsibility.* When scheduling a new client, TTM requires a credit card to hold the appointment. If the appointment is canceled with less than 24 hours notice TTM may collect the appointment fee. If a client habitually cancels or no-shows for appointments TTM will require a credit card to remain on file to hold their appointments. After 3 late cancellations, 2 no-shows, or after 5 cancellations of any notice, TTM reserves the right to require non-refundable pre-payment for sessions. TTM reserves the right to refuse service to any client for any reason at any time.

I understand that I am responsible for all charges for services provided. I understand that payment will be expected in full, regardless if the massage session is completed. I agree to the rates and policies posted above. In the event that my insurance or LOP injury settlement does not cover the amount billed or if I change or lose my attorney (if applicable), I am responsible for any balance due. If TTM pursues actions resulting from unpaid bills including Interplead, collections or the like, I am responsible for legal and attorney fees, collections fees, costs and damages. In the event the insurance company or LOP Attorney (if applicable) denies benefits or makes a partial payment, I am responsible for any balance due with interest.

Sessions may include any modality of bodywork within the therapist's ability and licensed scope of practice. I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately. I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes. I understand that massage is not a substitute for medical advice, diagnosis or treatment.

I understand that I will need to provide a signed consent of release in order for any of my records to be released to other practitioners or an attorney. My records may be sent, without notice or additional consent, to my referring practitioner, LOP attorney or insurance provider, upon their request, or as needed for billing and coordination of care. I am aware of TTM's healthcare information privacy notice and understand that I may request a copy of its privacy practices policies at any time.

I certify by signing below that I have read and agree to all of the above.

Client Signature:_____Date: _____