



Dr. Abdul Karim Taifour, LMP
Tel: 206-226-2527
www.massagedoctor.com

CLIENT INTAKE /
PERSONAL HEALTH
INFORMATION

PERSONAL DATA

Name Referred By
Address City, State, Zip
E-mail Date of Birth
Phone Day Evening Cell
Occupation, Employer
Emergency contact Phone(s)

MESSAGE HISTORY / TREATMENT INFORMATION

Have you ever received a professional massage? Yes No Date of last session Frequency
What results do you want from your massage sessions?
Prioritize the areas of your body that you would prefer to be massaged
Stress reduction and exercise activities and frequency

MEDICAL / HEALTH HISTORY

Are you currently seeing a medical practitioner? Yes No Please explain
Primary Health Care Provider Phone
Surgeries / Accidents (and dates)

AREAS OF HEALTH PROBLEMS (Please specify if yes):

- MUSCULO-SKELETAL
NERVOUS SYSTEM
DIGESTIVE
CIRCULATORY
PREGNANT - if yes, due date any complications
INFECTIOUS DISEASE
SKIN
MEDICATIONS (include aspirin, ibuprofen, herbal/other supplements)
OTHER

Anything else we should be aware of

Print Name: Signature: Date:

If applicable, Parent/Guardian Signature: Date:

Print Parent/Guardian Name & Relationship



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CONSENT FOR TREATMENT & CLINIC POLICIES

Consent for Treatment

I understand it is my choice to receive massage. I realize that the treatment is being given for the well-being of my body and mind; this includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel my well-being is compromised or if I feel any discomfort or pain.

I understand Dr. A.K.Taifour, LMP does not diagnose illness, disease, physical or mental disorder; nor prescribe medical treatment or pharmaceuticals; nor perform spinal thrust manipulations. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis. I agree to provide a recommendation from a health care provider if necessary to receive massage therapy.

I have stated all the medical conditions that I am aware of and will update Dr. A.K.Taifour, LMP as to any change in my health status. This consent form is valid for today's session and all subsequent sessions, unless revoked in writing by me.

Massage Doctor / Kneady Body & Feet Clinic Policies

Dr. A.K. Taifour, LMP participates with Kneady Body & Feet and provides services under the following clinic policies:

We are a clinic of massage associates. Each associate practitioner has his/her own state licensing, malpractice insurance and business licensing. They each operate their business in cooperation with Kneady Body & Feet Massage. You agree to not hold Kneady Body & Feet Massage, Tammy Foss, Lake Hills Professional Center, its tenants or owners, or any other clinic associate personally liable for legal and financial issues or situations that arise with your independent practitioner. Clinic management is always open for suggestions and open to hearing issues that may arise between you and a clinic associate. Every effort will be made by clinic management to provide you with the highest quality service and the best practitioners in Puget Sound.

We are a HIPAA compliant office. Your privacy is important to us. Your personal information will be protected within our clinic and not shared with anyone outside of Kneady Body & Feet Massage and its Clinic Associates. You may request a clinic association list from your practitioner. If your personal file needs to be reviewed by anyone outside of the clinic association, you will need to sign a release form.

We are educators. By agreeing to receive service at the clinic, you are opting in to receive education, announcements and offers through the mail from Kneady Body & Feet Massage Clinic & its Associates. Again, your personal information is never shared (nor sold) to third parties in compliance with HIPAA.

We are licensed therapists trained and licensed to help you heal. You are agreeing to work with a licensed massage practitioner as a client of WA state licensed massage services. You are agreeing to communicate with your practitioner immediately about any conditions or techniques during your work together that do not enhance your well-being. Failure to communicate all of your medical conditions may further damage your health. Any actions that may be construed as sexual advances or unsafe behavior will be reported to the police station.

We ask for your cooperation with our RULE of 24. In effort to provide all of our clients with outstanding service, 24 hours notice is required for all cancellation notices and rescheduling requests. Please respect our practitioners' time and our other clients' requests by providing us with 24 HOURS NOTICE.

When 24 hours notice is not provided, the following fees may be invoiced:

No-Shows = \$55 or the full rate of your appointment, which ever is greater.

Cancellation = \$24 for a called-in cancellation less than 24 hours (i.e. same day call-ins)

Rescheduling = \$15 for a called-in rescheduling less than 24 hours (i.e. same day call-ins)

Please note, that if you are more than 20 minutes late for a scheduled appointment, you may be required to reschedule and the rescheduling fee may apply. We reserve the right to treat each situation on a case-by-case basis. Payment due upon receipt of invoice.

Print Name: _____ Signature: _____ Date: _____

If applicable, Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name & Relationship _____



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INSURANCE INFORMATION

By signing below, you are acknowledging your financial liability for your requested services. Every effort will be made to collect billable charges from your insurance company. However, the therapist reserves the right to wait no more than 90 days following any billing procedure, and should payment be delayed or refused, you will be invoiced directly and you are responsible for paying all charges within 30 days of receipt of the invoice. All charges for treatment received prior to coverage verification are the patient's responsibility. We reserve the right to not re-bill insurance, or to bill secondary carriers. If you have Medicare, you must have a secondary insurance as Medicare does not cover massage. The patient is responsible for ensuring that insurance eligibility, coverage, authorization requirements and limitations, are all verified prior to treatment session.

** Please provide your doctor's referral, your driver's license or identification, and insurance card to be copied for your file. **

Current Condition(s) _____ Date of Injury or Symptom Onset: _____

Referring Physician Name _____ Phone _____ Fax _____

Health Insurance Plan Name _____ Member # _____

Are you the policyholder? Yes If not, policyholder name _____ & Date of Birth _____

Policy / Group _____ Phone _____ Fax _____

Address for Sending Claims _____

Are you receiving treatment today due to an accident? Yes No If yes, date of accident _____

Employment-related – please provide Labor & Industry Claim Number _____

Auto accident – please provide Driver's License – Issuing State _____ Number _____

Your Auto Insurance Company _____ Claim Number _____ Policy Number _____

Representative / Adjuster Name _____ Phone _____ Fax _____

Address for Sending Claims _____

Third-party / personal injury – please provide Insurance Company _____ Claim Number _____

Contact Name for Claims _____ Phone _____ Fax _____

Address for Sending Claims _____

Attorney Name _____ Phone _____ Fax _____

Attorney Address _____

My signature below also gives HIPAA-compliant permission for Dr. A.K. Taifour LMP to communicate with and exchange information with my insurance company and referring physician to coordinate care and processing of benefits and payments.

Print Name: _____ Signature: _____ Date: _____

If applicable, Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name & Relationship _____

Witness or Therapist (print name, sign): _____ Date: _____



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P.O. Box 27612, Seattle WA 98165
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REFERRAL
FROM DOCTOR
FOR MASSAGE

For Patient _____ Date of Birth _____
Insurance plan _____ Insurance member ID number _____
FROM DR. _____ NPI # _____
Address _____ City, State, Zip _____
Phone _____ Fax _____ Email _____

Note: for insurance coverage, ALL sections must be completed and clearly legible.

Start Date of Treatment: _____ Total Number of Visits: _____ Frequency: _____
(Note: insurance companies will accept referrals dated after treatment has started - start date of treatment should be first massage patient receives.)

TREATMENT IS MEDICALLY NECESSARY - Diagnosis & Condition Circled Below:

- 307.81 tension headache
353.0 thoracic outlet syndrome, brachial plexus lesions
354.0 carpal tunnel syndrome
526.9 jaw pain / TMJ
716.90 arthritis n.o.s.
719.41 joint pain, shoulder
719.42 joint pain, upper arm, elbow
719.43 joint pain, forearm, wrist
719.44 joint pain, hand
719.45 joint pain, hip, thigh
719.46 joint pain, lower leg, knee
719.47 joint pain, ankle, foot
719.48 joint pain, other specific site
719.49 joint pain, multiple sites
719.50 joint stiffness
719.60 joint symptoms, other
723.1 cervicalgia
723.4 brachial neuritis / radiculitis
723.5 torticollis, neck stiffness
724.00 spinal stenosis unspec
724.1 thoracic pain
724.2 lumbago, lumbar pain
724.3 sciatica
724.4 thoracic or lumbosacral neuritis or radiculitis
724.5 back pain n.o.s.
724.9 back disorder, other unspec
726.0 frozen shoulder
726.1 rotator cuff syndrome, shoulder disorder
726.3 enthesopathy, elbow tendonitis, golf or tennis elbow
728.85 muscle spasm
728.9 other muscle disorder
729.1 myalgia / myositis / fibromyalgia
729.4 fasciitis n.o.s.
729.8 other musculoskeletal symptoms
729.82 cramp of limb
729.99 other disorder of soft tissue
780.71 chronic fatigue syndrome
780.96 generalized pain
784.0 headache
786.59 chest / pectoral pain
839.00 cervical subluxation
839.20 lumbar subluxation
839.21 thoracic subluxation
839.79 subluxation, other site
840.9 shoulders-upper arms sprain/strain
843.0 iliofemoral sprain / strain
846.0 lumbosacral sprain / strain
846.1 sacroiliac sprain / strain
847.0 neck sprain / strain
847.1 thoracic sprain / strain
847.2 lumbar sprain / strain
847.3 sacral sprain / strain
847.4 coccyx sprain / strain
848.1 jaw / TMJ sprain / strain
848.9 sprain / strain n.o.s.

Prescriber's Signature: _____ Date: _____



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RELEASE OF INFORMATION

Authorization to release personal health information

I, (name) _____, Date of Birth: _____, give my permission to

Dr. A.K. Taifour, LMP, dba Massage Doctor, to exchange my health information checked below with:

Person _____

Company / Organization _____

Address _____

Phone _____ Fax _____

(Note: the typical options are in larger bold type)

- checkbox All of my health information that the provider has
checkbox All of my health information that the provider has covering a certain period of time:
checkbox All of my health information that the provider has relating to a certain event or injury:
checkbox My health information specifically regarding (if you do want this shared, your initials are required)
checkbox Other:

The provider may exchange the health information it has for me, for this purpose:

- checkbox For billing and payment purposes and for insurance processing
checkbox To coordinate care and treatment checkbox For a research study checkbox For marketing purposes
checkbox Other:

Terms of Authorization: The provider may share my health information from the date of this Authorization until I revoke it in writing. Per HIPAA regulations, I understand this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand I may be charged a processing fee by either party for this service. I understand I may revoke this authorization at any time in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization, and any revocation will not affect any actions taken before the receipt of the written revocation.

Print Name: _____ Signature: _____ Date: _____

If applicable, Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name & Relationship _____