Intake / Health History Form

Please fill out the form and return to the office using any of these 3 options (listed in order of security/privacy):

- Print and bring this form with you to your appointment (most secure) OR
- At least 24 hours prior to your appointment:
    - Fax the form to 406-319-5001. Free electronic fax options are available OR
    - Email to deb@debkimmet.com – this option is not secure and not HIPAA compliant

Name _____

Referred by _____ May we send them a thank you? ◯ Yes ◯ No

Date of Birth (mm/dd/yyyy) _____ ◯ Male ◯ Female ◯ Other ◯ Not specified

Email _____ Preferred Phone _____ ☐ Cell

Address _____ City _____ State _____ Zip _____

Emergency contact _____ Phone _____ Relationship _____

Primary Physician/Health Care Provider _____ Phone _____

Occupation _____

SECTION 1. General Screening

Please indicate if you are currently experiencing any of the following:

☐ Blood Clots ☐ Infections ☐ Congestive Heart Failure ☐ Contagious Diseases ☐ Pitted Edema

Massage may be contraindicated when the above conditions are present. Please call our office (406-544-4704).

Are you currently taking antibiotics? ◯ Yes ◯ No

The general guidance is to wait more than half-way through the course of treatment. If you have signs of heat, fever, swelling or pain, **do not schedule until those symptoms have resolved. Please call our office to discuss this further.**

SECTION 2. RSV / Flu / Covid-19 Screening

If the Answer to any of these questions is *Yes*, please reschedule to a date when the answer to all questions is *no*.
If, at any time, the answer changes from *No* to *Yes*, please reschedule to a date when the answer to all questions is *no.*

1. Symptoms: Have you or anyone in your household had ***any*** of the following symptoms in the last ***two weeks***? ◯ Yes ◯ No
    - Cold or flu-like symptoms? (Fever, chills, cough, sore throat, shortness of breath or other respiratory problem)
    - Recent loss of taste or sense of smell?
    - Fatigue?
    - New discomfort with exertion or exercise?
    - Unexplained sores on the feet?
    - Sudden unexplained bruising or rash?
    - Unexplained muscle/body aches or pain?
    - Nausea, vomiting or diarrhea?

    If you have been diagnosed with COVID-19 more than two weeks ago: Some of these are "long-hauler" symptoms and do not automatically disqualify you from receiving a session *UNLESS* you are experiencing fever, chills, cough, or sore throat. If you have these symptoms and have been diagnosed with COVID-19 more than two weeks ago, wait to schedule until 24 hours after those symptoms have stopped.
2. Have you or anyone in your household been diagnosed with RSV or COVID-19 within the last two weeks or are waiting for the results of a coronavirus test? ◯ Yes ◯ No

3. Have you knowingly had close contact with or cared for someone within the last two weeks who has been diagnosed with RSV or COVID-19 or is exhibiting cold or flu-like symptoms or other COVID-19 symptoms? ◯ Yes ◯ No
4. Have you been asked to self-isolate or quarantine within the last two weeks? ◯ Yes ◯ No

The day before your appointment, you will be sent a reminder about the COVID questions. How do you want to be contacted? Pick any or all

☐ By Phone Call ☐ By Text ☐ By email

#_____ #_____ email_____

Covid-19 Vaccination Status

Deborah Kimmet does not discriminate based on vaccination status. However, Deborah's clients include those who are immune compromised. These clients must be protected, and for safety reasons, unvaccinated people are not scheduled adjacent to each other or to immune compromised clients.

Have you received a Covid-19 vaccination? ◯ Yes ◯ No If yes, which one? _____

If yes: Are you fully vaccinated? Meaning that

1. For 2-shot vaccines (e.g. Pfizer or Moderna): Are you at least 2 weeks past the second shot? ◯ Yes ◯ No
   Or For 1-shot vaccines (e.g. Johnson & Johnson): Are you at least 2 weeks past the shot? ◯ Yes ◯ No

AND

2. Are you up to date on your booster shots? ◯ Yes ◯ No
   If No, Please Explain:_____

Note: Please do not schedule a massage within 2 days of receiving a vaccination due to potential side effects emerging during this window.

If you have had the Johnson & Johnson vaccine and are female between the ages of 18 – 48, please wait 2 weeks before scheduling your massage. If you develop any headaches or dizziness during this two weeks, seek out medical attention immediately.

SECTION 3. General Health History

PURPOSE OF VISIT: What do you wish to achieve from this work? / What are your goals?

Please indicate conditions that you currently have OR have had in the past.

Current	Past		Current	Past		Current	Past	
☐	☐	Allergies	☐	☐	Varicose veins	☐	☐	Dizziness
☐	☐	Asthma / Shortness of breath	☐	☐	Swelling	☐	☐	Ringing in ears
			☐	☐	Lymphedema	☐	☐	Frequent Indigestion
☐	☐	Respiratory illnesses	☐	☐	Osteoporosis	☐	☐	Other digestive conditions (Crohn's / IBS)
☐	☐	Arthritis	☐	☐	High / Low blood Pressure			
☐	☐	Diabetes				☐	☐	Hepatitis
☐	☐	Skin conditions	☐	☐	Cancer	☐	☐	HIV / AIDS
☐	☐	Easily bruised	☐	☐	Headaches / Migraines	☐	☐	Other infectious conditions
☐	☐	Stroke / Heart attack	☐	☐	Fainting Spells / Epilepsy / Seizures			
☐	☐	Heart disease				☐	☐	Depression / Anxiety
☐	☐	Kidney Disease / Infection	☐	☐	Endocrine / Thyroid conditions	☐	☐	Sleep Disturbance
☐	☐	Neurological (Parkinson's, MS, chronic pain)	☐	☐	Numbness / Tingling / Stabbing Pain			

Please provide details, including treatment received for the items checked above.

Please indicate Injuries / Trauma that you are currently recovering from OR have had in the past.

Current	Past		Current	Past		Current	Past	
☐	☐	Concussion / Head Injuries	☐	☐	Fractures	☐	☐	Dislocations
☐	☐	Hospitalizations	☐	☐	Surgeries	☐	☐	Other Injuries / Trauma

Please provide details, including the year treatment was received for the items checked above.

Women: Check the box if you:

☐ Have had a C-Section ☐ Are currently pregnant / Trying to get pregnant?

General: Check the box if you wear:

☐ Contacts ☐ Dentures ☐ Mouth Guard or other appliance ☐ Orthotics / Heel Lifts / Other Foot Support

Are you presently under the care of a medical professional (such as MD/DO, PT, Naturopathic Physician, Chiropractor, Acupuncturist, Mental Health Professional)? If so, please specify.

Medications: Please list your current medications and purpose of the medication.

SECTION 4. What brings you here today? Tell me more about it.

What is your major complaint?

_____

Severity on a scale of 1 to 10 (10 being the worst), rate your pain level _____

Other areas of pain or concern (minor complaints)?

_____

When did you first notice the major complaint?

_____

What brought it on? (include date of accident if applicable)

_____

What activities aggravate the condition?

_____

What activities relieve the condition?

_____

Is the condition getting progressively worse? ◯ Yes ◯ No ◯ It is constant ◯ It comes and goes

Is this condition interfering with your (check all that apply): ☐ Work ☐ Sleep ☐ Daily routine

At night it is ◯ Better ◯ Worse ◯ The same

What do you believe is going on with you?

_____

What have you done *this time* to get relief?

_____

Has there been a medical diagnosis? ◯ Yes ◯ No If yes, what was the diagnosis?

_____

By whom?

_____

Were there X-rays? ◯ Yes ◯ No Blood work? ◯ Yes ◯ No

Other diagnostic tests (Specify)?

_____

Have you ever had a similar problem before? ◯ Yes ◯ No If yes, when?

_____

What caused those episodes?

_____

What relieved them?

_____

What was the previous diagnosis?

_____

Is there anything else about your health that hasn't been asked that we should know in order to provide an effective session?

_____

DURING THE TREATMENT:

- Breathe! Exhaling releases tension. Holding your breath retains tension.
- Breathe! When the practitioner is applying pressure or stretching a muscle, also release your breath and your muscles will relax more easily.

SECTION 5. Consent to Treat / Waiver:

Marking each box below means that you have read and agree to all of the following statements:

COVID-19 Statements

The policies included here are put in place as a safety measure for all of us. Many clients are immune compromised, have a history of cancer, and/or are over age 60. It's Deborah's job to protect all of you, and to do that, you also have to protect Deborah. And even though people are more protected if they are vaccinated, a vaccinated person can still contract COVID-19.

☐ I understand that COVID-19

- Is extremely contagious and may be contracted from various sources, including droplets and aerosols.
- Has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. In addition, COVID-19 may also mimic symptoms of a cold or flu. This coupled with limitations in COVID-19 virus testing means that it may be difficult to determine who is infected with COVID-19 without testing.

☐ I understand that
- Massage therapy may provide an elevated risk of disease transmission, including COVID-19, because of the close physical contact over an extended period of time in an enclosed space.
- Preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented but these protocols do not fully mitigate the risk of contracting COVID-19.

☐ I understand that, until further notice, masks covering the nose and mouth are required. Deborah will provide me with a mask if I need one.

☐ I understand that my name and contact information might be shared with the state/local health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

☐ I agree to cancel my appointment if I or anyone in my household has been ill or if I have been exposed (or suspect that I've been exposed) to any contagious illness– even if it appears to be "just a cold." I understand that the symptoms of COVID-19 are similar to a cold or flu.
The cancellation policy will be waived when illness is involved provided that I give advance notice – even if the notice of cancellation is just a few minutes ahead of time. But I agree to provide more notice if I can.
I also understand that if I arrive at the office and I am ill or the screening questions indicate that I should not receive a session, the session will be cancelled and I will be charged for the session time.

☐ I agree that it is not unreasonable to wait two weeks before receiving massage therapy if I have participated unmasked in higher-risk activities in mixed crowds of vaccinated and unvaccinated people or situations where I don't know the vaccination status of those attending.

☐ I agree and understand that If Deborah or I test positive for COVID-19 (or have been exposed to COVID-19) within the 14-day window of our appointment, *OR* if either of us is showing any apparent symptoms, we will notify the other.

☐ I understand that I am the decision maker for my health care. To the best of her ability, Deborah Kimmet will provide me with information to assist me in making informed choices which also involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic.

☐ By signing this form,
- I have read, or have had read to me, the above COVID-19 risk information and I have also had an opportunity to ask questions about its content.
- I acknowledge that I am aware of the risks involved and assume the risk of becoming infected with COVID-19 through this treatment.

General Statements:

☐ I understand that I can ask for and receive a copy of this consent form or I can access it from https://www.debkimmet.com/client-resources.html (Clinically-based Session Intake Form)

☐ I understand the purpose of the session is intended to enhance relaxation, reduce stress, reduce pain caused by muscle tension, increase range of motion, improve circulation, and offer a positive experience of touch.

☐ I understand that if anything feels painful or uncomfortable I will tell my practitioner immediately so the technique may be adjusted to my level of comfort and safety.

☐ I understand that massage therapy, bodywork, movement education, and exercise should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. It is recommended that I inform my other caregivers that I am also receiving massage therapy, bodywork, movement education, and exercise as part of my self-care program.

☐ I understand that the practitioner is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe medication, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Information exchanged during a session is educational in nature and is to be used or followed at my own discretion and at my own risk.

☐ I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

☐ I understand the importance of disclosing my health history: Massage therapy, bodywork, movement education, and exercise should not be performed under certain medical conditions or accommodations may be required when certain healthcare conditions are present, I affirm that I have stated all my known medical conditions and medications and answered all questions completely and truthfully and understand that there shall be no liability on the practitioner's part should I fail to do so.

☐ I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. And I acknowledge that it is not possible to consider every possible complication to care.

By signing this form:

- I acknowledge and understand the risks involved in receiving massage therapy, bodywork, movement education, and exercise and I give my express permission to Deborah Kimmet to proceed with providing care.
- I agree to abide by the policies and statements outlined in this document.
- I agree with the current or future recommendation to receive care as is deemed appropriate for my circumstance.
- I intend this consent to treat to apply to any sessions from Deborah Kimmet from the date indicated below and any future sessions.

Client Signature* _____ Date _____

Consent to Treatment of Minor:
By my signature below, I hereby authorize Deborah Kimmet to administer massage therapy, bodywork, movement education, and exercise to my child or dependent as deemed necessary.

Signature of Parent or Guardian* _____ Date _____

*A typed full name is also a valid signature.

Assignment of Benefits / Information Release

ASSIGNMENT OF BENEFITS **Your Initials Here: _____**

To the Insurance Company:

- From FORM 1500: "INSURED'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned supplier [Deborah Kimmet] for services described [on FORM 1500]." "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: … I also request payment of government benefits … to the party who accepts assignment [on FORM 1500] [Deborah Kimmet]."
- I hereby direct and instruct the insurance company to make payments directly to the undersigned supplier for medical claims submitted by them on my behalf for medically necessary treatment. Provide Deborah Kimmet with any and all information regarding my policy benefits and coverages. Your denial or delay to do so in a timely manner will be considered just cause for myself or provider to file a complaint with the Insurance Commissioner. I hereby give my permission to the undersigned supplier to file this complaint on my behalf if deemed necessary.

RELEASE OF RECORDS **Your Initials Here: _____**

To the Supplier of Services: Deborah Kimmet Massage & Movement, LLC:

- From FORM 1500: "PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim [on FORM 1500]."
- I hereby authorize you to release to any physician, healthcare provider, or insurance company involved in my case, any medical or other records or information necessary for the following purposes:
    - To process my claim. These records are to be utilized for the ultimate recovery of benefits in my case for the injury sustained on (date) _____.
    - To facilitate the treatment program provided by Deborah Kimmet Massage & Movement, LLC for the injury sustained on the date above.

  I also authorize the providers listed below to release information to Deborah Kimmet Massage & Movement, LLC for the same purposes above.

  Insurance Company: _____

  Name of Referring Provider: _____

  Other Healthcare Providers: _____

  You will not release information to any attorney without my permission. I permit you to release information to the attorney named here: _____.

I have read and agree to the terms for the Assignment of Benefits and the Release of Records as described above.

Signature: _____ Date: _____

Print Name: _____

Supplier's Signature: _____ Date: _____

Deborah Kimmet Massage & Movement, LLC

Cancellation & Payment Policies

For Workers' Compensation Insurance Clients

CANCELLATION & LATE ARRIVAL POLICY

- **At least 24-hour notice of cancellation is expected**. If less than 24-hours' notice occurs, that appointment will be considered **Cancelled without notice** (See COVID-19 / Other Illness Considerations for more).
- **If a client is late for a session**, the late time will be deducted from the session time and billed accordingly.
    - An appointment is considered **cancelled without notice** if a client is 15 or more minutes late. To avoid automatic cancellation call or text Deborah before the 15 minutes have elapsed. The basic policy regarding lateness still applies.
- **COVID-19 / Other Illness Considerations**. This policy is for the health and safety of both parties to avoid spreading illness which can result in lost work days. Deborah will not knowingly expose her clients to illness and she expects the same of her clients.
    - A client should not schedule an appointment if they cannot pass the COVID-19 / RSV screening. And a client should reschedule as soon as possible if they no longer pass the screening.
    - If symptoms or exposure occur within the 24-hours prior to your session, the client must cancel the appointment. The action will ***not*** be considered **cancelled without notice *IF*** the client, within 24 hours of the appointment, was:
        - Diagnosed with or tested for COVID-19 or
        - Experiencing cold or flu-like symptoms (including fever, chills, cough, or sore throat), loss of taste or smell, or other COVID-symptoms (Note that COVID-19 has cold-like symptoms, so even if you think you have a cold, you do not pass the screening) or
        - Exposed to someone who meets the criteria above.
    - If a client is symptomatic when they arrive or does not pass COVID-19 screening, the session will be cancelled and the session will be considered **cancelled without notice.**
- As with all policies, there are exceptions and special cases. For more information see "Other Considerations" below.

Sessions cancelled without notice:

- It is illegal to charge an individual for a missed session. Therefore, if permitted by the insurance company, Deborah Kimmet will bill the insurance company for the missed session.
- Sometimes life intervenes and a cancellation without notice cannot be avoided. However, if it appears that the situation could have been avoided, Deborah may require that a new primary care provider prescription or referral be obtained before resuming sessions.

PAYMENT POLICY

A client is ultimately responsible for all charges incurred, whether or not insurance pays for the services rendered. For worker's compensation claims, by law, a client is not responsible for payment. In all other circumstances, where it is not prohibited by law, the client pays for any services received from Deborah Kimmet Massage & Movement, LLC if the insurance company doesn't pay.

I have read and agree to the terms of the cancellation and payment policies as described above.

Signature: _____ Date: _____
*A typed full name is also a valid signature.

Print Name: _____

Other Consideration for the Cancellation & Late Arrival Policy

This policy is designed to be fair to both the client and the practitioner. As such, other cases may arise when it would make sense to waive the policy:

- Medical emergency or death in the family.
- During winter weather advisories when warnings against non-essential travel are issued.
- On a case-by-case basis at the discretion of the practitioner.

Please contact Deborah to ensure that your treatment is not suspended due to cancellation without notice.

Antibiotics: A client taking antibiotics shouldn't receive a session near the beginning of the treatment course. General guidance is to wait until more than half-way through the course of treatment, but it depends on the type of antibiotic and at what point the antibiotic is at its most effective. If a client has signs of heat, fever, swelling, or pain, the session will be cancelled. Discuss this with Deborah per the 24-hour policy.

Privacy Policy / Provider Background

Privacy Policy:

This policy outlines how your records are used.

By signing below, you agree to the following statement:

> I understand that I can ask for and receive a copy of the privacy policy or I can access it from https://www.debkimmet.com/client-resources.html (scroll down to Legal Disclosure: Privacy Policy)

Provider Background:

This document outlines your provider's legal status (experience and training).

By signing below, you agree to the following statement:

> I understand that I can ask for and receive a copy of the Provider's Background or I can access it from https://www.debkimmet.com/client-resources.html (scroll down to Legal Disclosure: Provider Background)

Signature: _____ Date: _____
*A typed full name is also a valid signature.

Print Name: _____