260 S. Main St. Seneca, IL. 61360
Office# 815-357-6858 Fax# 815-357-6857

Massage Therapy Intake Form

Date:___________________

Patient Name:____ ***M/F*** (circle)

(First Name) (Middle Initial) (Last Name)

Mailing Address:____

(Street No./Name) (City) (State) (Zip)

Home Phone:_____________ Work Phone:_______________ Cell Phone:______________

SS#______-____-______ DOB:_____/______/_____ Age:____ Marital Status___________

Employer:___________________ Occupation:______________ Referred By:____________

Date Of Injury, If an accident:___________________ (Auto, Personal Injury, Home/Work related)

Drivers License #_______________________ Spouse/Parent Name:__________________

Spouse/Parent Employer:_________________________ Work#:_____________________

Primary Insurance Co.:__________________ ID#:_______________ Group#:____________

Policy Holders Name:____________________ Policy Holders DOB _____/_____/_______

Secondary Insurance Co.:_________________ ID#__________ Group#_________________

Policy Holders Name:____________________ Policy Holders DOB_____/_____/________

________(initial) **RIVERSIDE CHIROPRACTIC CENTER** has my permission to leave a message on my voicemail or with a family member.

Insured's Signature:____ **Date:**___________

Riverside Chiropractic Center of Seneca, Ltd.

Informed Consent for Massage Therapy

I understand that Massage Therapy is for the purpose of stress reduction, relief from muscular tension, general relaxation and improvement of circulation. I understand that the Massage Therapist does not diagnose illness, dis-ease or any other physical or mental condition and that no conversations or statements made during or relating to our sessions should be construed as such. The Massage Therapist neither prescribes medical or pharmaceutical treatment nor performs any spinal adjustments. It has been made clear to me that professional Massage Therapy is not a substitute for medical or chiropractic treatment. I understand that it is recommended that I see a physician to verify that there is no medical reason that I should not undergo Massage Therapy and for any physical ailment that I might have. I acknowledge that any sexual or implied sexual comments or actions on my part will result in immediate termination of the massage session and I will be responsible for any and all charges in full. I understand that I may be held responsible in full for any missed appointments without prior notice or for any cancellations made less than 24 hours in advance.

I have read and understand the above statement. I have stated all of my known medical conditions on the Patient History Form. I take it upon myself to keep the Massage Therapist updated on my current health.

HAVING THIS KNOWLEDGE, I KNOWINGLY AUTHORIZE RIVERSIDE CHIROPRACTIC CENTER TO PROCEED WITH MASSAGE THERAPY CARE AND TREATMENT.

CONSENT TO TREAT MINOR

I hereby authorize Riverside Chiropractic Center of Seneca, Limited and whomever they may designate as Massage Therapist and assistants to administer therapy as they do deem necessary to my Son / Daughter, ____
(circle one) (child's full legal name)

I authorize Riverside Chiropractic Center of Seneca, Limited and said Therapists and Assistants to treat the above listed child in the absence of my presence under normal office visit circumstances. ___________________________________ Date: ________________
(parent/guardian signature)

Having the above knowledge, I knowingly authorize Riverside Chiropractic Center to proceed with Massage Therapy care and treatment.

Self or Parent/Guardian Signature: __________________________ Date: _______________
(if patient is a Minor)

Massage Therapist Signature: ______________________________ Date: _______________

Riverside Chiropractic Center of Seneca, Limited **Office Policy** *(Revised Oct.2024)*

RCC does accept self-pay patients as well as a large number of insurance carriers. As a Blue Cross/ Blue Shield of IL (BCBSI) PPO contracted provider, RCC will file and accept assignment for all BCBSI patient claims. For all other insurance carriers, including Medicare, **you pay for your visit at the time of service**, we file your claims to your carrier, then you will be reimbursed by your carrier. To be able to file your claim in an efficient and timely manner, you must provide us with the complete insurance information including primary and secondary insurance company names with complete addresses, policy numbers and group numbers. **If at any time there is a change in your insurance**, please contact us with the correct information as soon as possible.
*It must be understood that the contract is between you and your insurance company. You are **fully responsible** for any amount not paid by your insurance for any reason. ***We cannot guarantee that insurance will pay***. RCC will not enter into a dispute over your insurance claim. This is your responsibility and obligation.
***If you have BCBS, your copays are due at the time of service.** BCBS patients will not be responsible for any amount over BCBSI maximum allowances should our fees exceed these limits.
***Medicare** does not pay for physical exams, x-rays or any type of massage therapy. You are therefore responsible for the balance of these services at the time they are rendered. Medicare fees will be adjusted in compliance with non-participating fee limits.
***Auto Accident & Personal Injury (PI) patients** must provide us with all the correct information needed. **RCC will not increase or decrease its fees and services according to the settlement received.** We will bill your insurance, i.e. Med Pay. Your insurance company is expected to pay until a settlement is reached. At that time the insurance company of the person deemed responsible for the collision will reimburse the other insurance company. **We are unable to hold accounts receivable throughout the duration of the case, litigation or arbitration, therefore if for any reason timely payments are not being made by the insurance, you will be responsible for making payments.**
***Worker's compensation** patients must present all required insurance information ASAP. Patients must identify their injuries as a work injury prior to exam and treatment. Fees will be adjusted according to Illinois state limits. If your worker's comp. case is closed, you may continue care with us, but will be responsible for the bill at the time of service.
***If a payment is not received by 60 days of services rendered, RCC reserves the right to refer your account to a collection agency. If you fail to pay on time and RCC refers your account(s) to a third party for collection, a collection fee of 33.3% will be assessed and will be due and owing at the time of the referral to the third party. A 2% billing charge will be added for each month that the account is past due, as well as reasonable attorney fees and court costs should the account go to litigation.**
*Beginning January 1, 2020, a **$10.00** statement charge will be added to accounts with a balance 60 days past due, for each month balance is due, until paid, to help defray the cost of sending out statements.
*Beginning May 1, 2022, a **3.75%** fee is charged for all credit/debit cards and any health saving cards processed.
***Returned checks** will be charged **$50.00**. The amount of check and fees will have to be paid with secure funds.
***Payment Plan**: When in need, an individual payment program may be established for you prior to rendering of services. The balance will never be allowed to exceed $200.00 while on a payment plan. You will also be required to pay 50% of any new visits, at the time of the visit. A billing charge of 2% for accounts over 30 days and the $10.00 statement charge will be added. A guarantee of payment with credit, debit card or check must be used. If monthly payment is missed, the credit or debit card will be charged and no statement charge added.
*A copy of our fee schedule may be requested.
*If you discontinue care without doctor's release, the balance will be due and payable in full at that time.
Riverside Chiropractic Center will do our very best to keep on schedule to minimize any inconveniences to our patients. We ask that our patients continue with this effort by making and keeping appointment times. We require at least 24 hour notice should you need to cancel your appointment.
* ***As of July 15th, 2022, Riverside Chiropractic Clinic will be enforcing our current Massage and Office Policy. Missed and non-cancelled appointments will be billed to your account at the rate of 50% of the total cost of the scheduled appointment. Your copay or coinsurance is invalid if you miss or do not cancel within 24 hours or in a timely manner.***
Patients will only be accepted if patient and/or guarantor understand and accept our policy in its entirety. If you understand and agree with all of the office policies, please sign and date below.
I authorize RCC to release any of my information that is needed to file my insurance claim.

_______*(please initial)* **Assignment of benefits: If I am a BCBSI, WC or PI patient,** I hereby authorize payment of medical (chiropractic) benefits to the provider of services as indicated on the submitted claims.
_______ *(please initial)* I am aware and understand RCC's Protected Health Information **(HIPPA**) Policy is available to me in the white 3 ring binders in the waiting room and consultation room. All of my questions have been answered to my satisfaction and I agree to the policy terms.

Printed Patient Name

Patient (Guarantor) Signature Date

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Riverside Chiropractic Center of Seneca, Ltd.

Client History Form

Name:____Date:__________________

Date of Birth:________________Age:__________ Occupation:__________________

Home Phone #:____________________Work Phone #:______________________

Referred By:__________________Are you currently pregnant?______ If yes due date:______

Is this your first Massage?:____________Primary Reason for Appointment:______________

Are you currently Under the Care of a Physician. If Yes, Please Explain:______________

____

Physician's Name:_____________________________Phone:__________________

If you have had surgery within two years, Details Please:____________________

____

Current Health

Please check if you have any of the following:

___Contact Lenses	___Dentures	___Asthma	___Heart Conditions
___Abdonminal Pain	___Blood Clots	___Varicose Veins	___Spinal Conditions
___High Blood Pressure	___Arthritis	___Infection(s)	___Cancer
___Low Blood Pressure	___Digestion Problems	___Bruise Easily	___Joint Problems
___Circulatory Conditions	___Difficulty Breathing	___Diabetes	___AIDS/HIV
___Osteroporosis	___Migraines	___Pacemaker	___Transdermal Patch
___Muscular Injuries	___Ticklish	___Phlebitis	___Thrombosis
___Respiratory Disease	___Allergies (Please List):______________		

___Skin conditions (please list):______________________________

Do you have any allergies/sensitivities to ___Oils ___Lotions ___Foods

Do you have any other medical conditions which may be pertinant?:______________

____

Please Mark With an "X" any Areas You Are Feeling Discomfort: