Evonda Timbers Massage Therapy

"Specializing in Customized, High Quality Massage Therapy Treatments"

770 River Road 2nd FLR
Fair Haven, NJ 07704
908-902-1579

MVA/PIP CLAIM PACKET

Hello and thank you for choosing Evonda Timbers Massage Therapy for your massage therapy needs. We are thrilled to have you join our family and look forward to providing you with the highest quality massage therapy during your recovery and beyond.

Enclosed in this packet are the following forms:

~Confidential Personal Health Information Form
~ Policies
~Massage Therapy Prescription Form***
~Motor Vehicle Accident Questionnaire
~ Injury Information
~ Pain Questionnaire

You must fill out each form and sign it prior to your first session.

On the day of your appointment please bring with you:
All forms in this packet filled out and signed
***Please note that you can bring our copy of the "Massage Therapy Prescription Form" to your physician to fill out and sign to make it easier. However, if your physician prefers to fill out his/her own prescription we will gladly accept it as long as it has the necessary information on it required by the insurance company:

Start Date Diagnosis (include ICD-9)
# of sessions or frequency/duration of sessions. (i.e. 2 sessions per month for 4 months)

If you do not have a prescription from a physician we will not be able to bill your claim and you will be responsible for the entire balance owed. New Jersey law does not allow massage therapists to bill insurance claims without a valid prescription.

If you have any questions please email us at:
evondat@massagetherapy.com or visit us at www.evondatimbers.massagetherapy.com

Confidential Personal Health Information

•PERSONAL DATA Referred By: Internet/Physician/Friend/Relative _____

Name: _____ Phone numbers:
Address: _____ Mobile:_____
City: _____ State: _____ Zip: _____ Home: _____
Work: _____
Birthday: _____ Age: ___

Email address: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Primary Physician: _____ Phone: _____

•METHOD OF PAYMENT

☐Car Accident Claim #_____

•MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐**Yes** ☐ **No**
If yes, frequency and type of massage: _____ Date of last massage:
_____
Are you currently seeing a medical practitioner? (MD, Chiropractor, Physical Therapist etc.) ☐**Yes** ☐ **No** If yes, please explain:
_____
_____

List stress reduction/exercise activities (include frequency)
_____
_____

List current medications (include ibuprofen, aspirin etc.) Give dosage and condition
_____
_____

•PREVIOUS HISTORY (include year and treatment received)

Surgeries:
_____
_____

Accidents (automobile, falls etc.):
_____
_____

Allergies (food, medications, drugs, chemicals):
_____
_____

Reason for today's visit?_____ Main problem(s) that you want to focus on? _____

How long have you been experiencing symptoms/problems associated with this issue?_____

Have you received a diagnosis from a physician for your symptoms? ☐**Yes** ☐ **No** If so, what is your diagnosis?
_____
_____

Illnesses/pathologies/conditions

Please mark any categories in which you have had or currently have. Please briefly describe each condition that is marked. Please also indicate which side of body when applicable.

Skin:

☐Rashes
☐Athlete's foot
☐Herpes/Cold sores
☐Allergies
☐Other: _____

Circulatory

☐High/Low blood pressure
☐Heart Problems
☐Phlebitis/Varicose Veins
☐Blood Clots
☐Shortness of breath
☐Chest pain
☐Stroke
☐Poor circulation
☐Other _____

Habits

☐Tobacco
☐Alcohol
☐Drugs
☐Coffee

Muscles/Joints:

☐Arthritis
☐Joint or bone disease
☐Tendonitis/Bursitis
☐Sprains/Strains
☐Osteoporosis
☐Neck/Shoulder/Arm Pain
☐Low Back/Hip/Leg Pain
☐Spasms/Cramps
☐Jaw Pain/TMJ
☐Lupus
☐Other: _____

Other

☐Sleep disorder
☐Chronic Pain
☐Chronic fatigue
☐Cancer/Tumors
☐Migraines/Headaches How many weeks? _____
☐Anxiety/Stress disorders

Nervous System:

☐Pinched Nerve
☐Numbness/Tingling
☐Sciatica/Shooting pain
☐Other: _____

Digestive

☐Gas/Bloating
☐Constipation
☐Irritable Bowel Syndrome
☐Ulcers
☐Other _____

Reproductive

☐Ovarian/Menstrual
☐problems
☐Pregnant
☐PMS
☐Prostate problems

Additional comments:

_____
_____
_____
_____

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service. I have stated all known medical conditions and will update the massage practitioner in writing of any changes in my health status if necessary.

Signed: _____ Date: _____
(Client or responsible party)

Policies

***Specialized Healthcare**

First and foremost, please recognize that we are healthcare providers at which we take our chosen career very seriously. We are personally committed to the overall well being of each of our clients. We ask that you respect our time together as much as we do. Also, realize the time you have taken for yourself is not a pampering service, but a form of specialty healthcare that has tremendous beneficial outcomes. We specialize in customized, high quality massage therapy treatments as a means for you to live a healthy life. Our focus and promise is to provide you with the highest quality massage therapy treatments so that you may recover from pain & injuries, as well as take preventative measures for a healthy future in receiving regular massage sessions.

***Payment**
Personal Injury Protection (PIP) claim and are currently receiving massage therapy treatment, we will bill your claim on your behalf. If payment is not made by insurance within 6 months (180 days of billed date) patient is responsible for payment. Cash, checks and credit cards are acceptable methods of payment at this time

Cancellation Policy
We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24 hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows
Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for their "missed" appointment.

Late Arrivals
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

I have read, understand, and agree to the above policies

Signed: _____Date:_____
(patient or responsible party)

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Massage Therapy Prescription Form

Date: _____

Prescribing Physician print):_____
Clinic Name:_____Address:_____
Phone: _____ Fax: _____
Prescribed Patient: _____

Diagnosis Codes

☐354.0 Carpal Tunnel Syndrome	☐784.0 Headache	☐847.4 Coccyx Strain/Sprain
☐723.1 Cervicalgia	☐840.4 Rotator Cuff Strain/Sprain	☐848.1 T.M.J Strain/Sprain
☐723.2 Cervicocranial Syndrome	☐840.9 Upper Arm/Shoulder	☐940.4 Rotator Cuff Sprain
☐723.3 Cervicobrachial Syndrome	Sprain/Strain	☐648.70 Pregnancy
☐723.4 Radiculitis/Brachial Neuritis	☐841.9 Forearm/Elbow Back Pain	☐724.3 Sciatica Sprain/Strain
☐724.5 Back Pain	☐843.9 Lower Hip/Thigh	☐Other_____
☐726.12 Bicipital Tenosynovitis	Sprain/Strain	☐Other_____
☐729.1 Myalgia/Myositis/Fibromyalgia	☐846.0 Lumbosacral Sprain/Strain	☐Other_____
☐729.5 Leg/Arm Pain	☐847.0 Cervical Strain/Sprain	☐Other_____
☐739.1Cervical Subluxation	☐847.1 Thoracic Strain/Sprain	☐Other_____
☐739.2Thoracic Subluxation	☐847.2 Lumbar Strain/Sprain	☐Other_____
☐739.3Lumbar Subluxation	☐847.3 Sacral Strain/Sprain	☐Other_____

Access and treat as needed

Treatment Goals:

☐Increase ROM/Mobility _____ times per week for _____ weeks
☐Restore Posture OR # of treatments _____
☐Decrease Pain
☐Decrease Muscle Tension/Spasms
☐Restore Function
☐Other
☐Other _____

Duration & Frequency of Treatment:

Condition Related To:

☐MVA
☐General Health _____

Notes:_____
_____
_____
_____

Signature of Physician: _____

Date: _____ NPI: _____

Motor Vehicle Accident Questionnaire

Patient Name: Date of Birth:
Accident Claim #: Date of Accident:
Your Car Insurance Company: _____ Policy #: _____
Insurance Company Address: _____
City:_____ State: _____Zip:_____ Phone Number: _____
City & State Accident Occurred: _____ Claim Agent: _____
Phone Number: _____ Fax: _____
Attorney's Name (if applicable): _____ Phone: _____

Primary Insured: Self ☐ Spouse ☐ Other ☐ Name of Insured (if not If self):_____
Date of Birth of insured: Employer: _____

Medical Bills and Records Should Be Billed To: (check one)
☐my car insurance company ☐the insurance company of the other vehicle (fill in the at fault insurance information below)

Name of other driver and/or insured name: _____ Phone: _____
Address: _____ Date of Birth: _____/_____/_____
City: _____ State: _____ Zip: _____
Insurance Company Name: _____
Claim Address: _____
City: _____ State: _____ Zip: _____
Policy Number: _____
Name of Insurance Adjustor: _____ Phone: _____

Release of Information & Financial Policy

My signature below authorizes and directs payments of medical benefits for services billed to my health care provider. My signature below also authorizes the release of my medical records including intake forms, chart notes, reports, and billing statements to my attorneys, health care providers, and insurance case managers, for the purpose of processing my claims. (I will inform my practitioner immediately upon signing any exclusive Release of Medical Records with my attorney). In addition, I understand it is my responsibility to pay for all services provided. In the unfortunately event that the insurance company denies payment or makes a partial payment, I am responsible for the balance.

Signature: _____ Date: _____

INJURY INFORMATION

Patient Name_____Date_____

Date of Accident_____ Insurance ID#_____

General Injury Information

1. How did the accident occur?
□ Auto □ On-the-Job □ Other_____

2. Did the police arrive at the accident? □Yes □No
Was a police report filed? □Yes □No
Was a work incident report filed? □Yes □No

3. Describe your injury and how it occurred:
_____
_____
_____
_____
_____

4.Describe how you felt during and immediately afterthe injury:
_____
_____
_____
_____
Later that day:_____
_____
The next day:_____
_____

5. Are your symptoms □ getting better
□ getting worse □ no change
What make them better?_____
_____
_____
Worse?_____
_____
_____

6. Did you return to work on the day of the injury? □Yes □No
Have you lost time from work since the injury? □Yes □No

7. Which work activities are affected by this injury?_____
_____
_____
Have your work responsibilities changed as a result of this injury? □Yes □No
Explain_____
_____
What other daily activities are affected by this injury?_____
_____

8. Did you go to the emergency room? □Yes □No
Were you hospitalized? □Yes □No

9. Have you ever had this type injury before?
□Yes □No
Explain_____
_____

Did you have any other physical complaints before the injury? □Yes □No
Explain_____
_____

Do you have any illnesses or previous injuries that may have been affected by this injury? □Yes □No
Explain_____
_____

Signature: _____ Date: _____

Evonda Timbers Massage Therapy

Patient Name: _____ Date: _____
Area of Pain: _____

Pain Questionnaire Form

PIP Claim # _____ _____

This questionnaire is intended to help provide your therapist with information that helps to understand how your level of pain is affecting your everyday life activities. Please answer each and every section and only mark the **ONE** box per section that applies to you currently. While it's understandable that it may be difficult to choose just one, please choose only one box that relates as closely as possible to your current state **today.**

Section 1 – Pain Intensity
- ☐I have no pain at this very moment
- ☐The pain is very mild at the moment
- ☐The pain is moderate at the moment
- ☐The pain is very severe at the moment
- ☐The pain is fairly moderate at the moment
- ☐The pain is the worst imaginable at the moment

Section 2 – Personal Care
- ☐I can do as much work as I want to
- ☐I can do my usual work but no more
- ☐I can do most of my usual work but no more
- ☐I cannot do my usual work
- ☐I can hardly do any work at all
- ☐I can't do any work at all

Section 3 – Driving
- ☐I can drive my car without any pain
- ☐I can drive my car as long as I want with slight
- ☐I can hardly drive at all because of severe pain
- ☐I can't drive my car at all

Section 4 – Reading
- ☐I cannot read at all
- ☐I can hardly read at all because of severe pain
- ☐I can read as much as I want to with no pain
- ☐I can read as much as I want to with slight pain
- ☐I can read as much as I want to with moderate pain
- ☐I can't read as much as I want to because of moderate pain

Section 5 – Headaches
- ☐I have no headaches at all
- ☐I have slight headaches which come infrequently
- ☐I have moderate headaches which come infrequently
- m ☐ I have moderate headaches which come frequently because of pain
- ☐I have severe headaches which come frequently
- ☐I have headaches almost all of the time

Section 6 - Sitting
- ☐I can sit in any chair s long as I like.
- ☐I can only sit in my favorite chair as long as I like
- ☐Pain prevents me from sitting more than 1 hour
- ☐Pain prevent me from sitting more than 10 minutes
- ☐I avoid sitting because it increases my pain straight away

Section 7- Standing
- ☐I can stand as long as I want without pain
- ☐I have some pain on standing but it does not increase with time
- ☐I cannot stand for longer than 1 hour without increasing pain
- ☐I cannot stand for longer than 1/2 hour without increasing pain
- ☐I cannot stand for longer than 10 minutes without increasing pain
- ☐I avoid standing because it increases my pain straight away

Section 8 - Concentration
- ☐I can concentrate fully when I want to with no difficulty
- ☐I can concentrate fully when I want to with slight difficulty
- ☐I have a fair degree of difficulty in concentrating when I want to
- ☐I have a lot of difficulty concentrating when I want to
- ☐I have a great deal of difficulty in concentrating when I want to
- ☐I cannot concentrate at all

Section 9 - Work (washing, dressing, etc.)
- ☐I can look after myself normally without causing pain
- ☐I can look after myself normally but it causes extra pain
- ☐It is painful to look after myself and I am slow and careful
- ☐I need some help but manage most aspects of self care
- ☐I need help every day in most aspects of self care
- ☐I do not get dressed, I was myself with difficulty and I stay in bed

Section 10 - Lifting
- ☐I can lift heavy weights without extra pain
- ☐I can lift heavy weight but it causes extra pain
- ☐Pain prevents me from lifting heavy weights off the floor, but I can
- ☐I can lift very light weights
- ☐Pain prevents me from lifting heavy weights
- ☐ I can manage light to medium weights if they are conveniently positioned

Section 11 - Sleeping
- ☐I have no trouble sleeping
- ☐My sleep is slightly disturbed (less than 1 hour sleepless)
- ☐My sleep is mildly disturbed (1-2 hours sleepless)
- ☐My sleep is moderately disturbed (2-3 hours sleepless)
- ☐My sleep is greatly disturbed (3-5 hours sleepless)
- ☐My sleep is completely disturbed (5-7 hours sleepless)

Section 12 - Recreation
- ☐I am able to engage in all my recreational activities with no pain
- ☐I am able to engage in all my recreational activities with some pain
- ☐I am able to engage in most, but not all of my usual recreational activities because of pain
- ☐I am able to engage in a few of my usual recreational
- ☐I can hardly do any recreational activities because of pain
- ☐I can't do recreational activities at all

Section 13 - Walking
- ☐I have no pain walking
- ☐I have some pain on walking but it doesn't increase with distance
- ☐I cannot walk more than 1 mile without increasing pain
- ☐I cannot walk more than 1/2 mile without increasing pain
- ☐I cannot walk more than 1/4 mile without increasing pain
- ☐I cannot walk at all without increasing pain

Signature: _____Date: _____