

BOTHELL INTEGRATED HEALTH, LLC
Therapeutic Massage

NEW PATIENT INFORMATION

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (cell) _____

Date of Birth _____

Emergency Contact Information:

Name _____ Phone _____

Relationship to you _____

PLEASE READ CAREFULLY AND SIGN BELOW

I understand that payment for treatments I receive at this facility is my personal financial responsibility. I agree to make full payment at the time of treatment. I understand that if I don not make full payment at the time of treatment, a \$5.00 billing charge will be added to the charges I owe.

I further understand that I may be charged for appointments cancelled with less than 24 hours notice.

Patient Signature
(If patient is a minor, signature of parent or guardian is required)

WELCOME TO BOTHELL INTEGRATED HEALTH

You have made an appointment at Bothell Integrated Health for massage. Your therapist is a professional health care provider who will work with you and your physician to help you achieve your health care goals. Your first appointment with your therapist may last up to 1 hour, due to the time it takes to accomplish the initial assessment of your injuries or condition, and to determine a treatment plan which best suits your needs. Subsequent therapy sessions will last one hour. **Please keep in mind that your Therapist has reserved this time exclusively for you and will not treat any other patients during this time period.** If you find that you will not be able to keep your appointment, please do us the courtesy of calling to inform us so that we may offer the time slot to another patient. Appointments cancelled with less than 24 hours notice will be subject to a \$35 fee. A patient who arrives more than 15 minutes late for an appointment may be asked to reschedule that appointment. We appreciate your consideration and ask that you fill out the intake forms completely so that your Therapist is able to provide you with the most effective treatment possible.

I have read the above statement and I understand that I am responsible for paying to Bothell Integrated Health a \$35 fee for any appointment missed without at least 24 hours prior notice.

Signature: _____ Date: _____