PATIENT EDUCATION & VERIFICATION / INSURANCE ASSIGNMENT

The insurance company has entered into a contract with its members, which we, as a provider, adhere to. Patients are responsible for all deductibles, co-insurance, and non-covered services. We cannot alter your insurance contract, including out-of-network terms.

PATIENT ACKNOWLEDGMENT

1. Reason for visit (pain, headaches, spasms): ☐ Yes ☐ No
2. Receiving No-Fault or Workers' Compensation? ☐ Yes ☐ No
3. Insurance may contact you to verify treatment.
4. Coverage Limits: Is medicare Insurance your Primary? ☐ Yes ☐ No
5. Massage Therapy: **20 visits**/year Is this the first visit or the year 2026? ☐ Yes ☐ No
6. Acupuncture: **20 visits**/year Is this the first visit or the year 2026? ☐ Yes ☐ No
   (Includes services received at other facilities; excess visits are patient responsibility.)
7. Medical Treatment with Nerve Block or Trigger Point Therapy Allows 1 visit per week
8. Requirements for Treatment:
   Medical evaluation by a doctor
   Valid referral & prescription
9. Billing Disclosures:
   Massage billed as Massage Therapy (may appear as Medical Services on EOB)
   Acupuncture/Trigger Point may appear differently on EOB depending on treatment
10. Tips are appreciated, but not required.
11. Cancellation Policy:
    Less than 24 hours' notice or missed appointment (non-emergency) = **$75 fee** (card on file).
12. Patient must obtain follow-up and prescription.
    Referrals must include diagnosis, DOB, address, and provider contact.

INSURANCE ASSIGNMENT & RELEASE

I certify I have active insurance coverage with _____ and assign benefits to:
Scarlett Sky Wellness Massage PC | Starwood Acupuncture PC LLC | A to Z Medical PLLC.
I _____ understand and agree, have been advised that the medical services I am receiving are being rendered by an out-of-network provider. As such I agree to the following:
I am financially responsible for all charges, whether covered or not.
My signature authorizes claim submission and release of medical information.
Providers may use/disclose my information for billing and insurance purposes.

OUT-OF-NETWORK ACKNOWLEDGMENT

Payments may be issued directly to me by my insurance carrier.
I agree to submit all payments and EOBs within 30 days.
Failure to do so may result in collections, and I am responsible for all fees.
Missing payments may require me to request reissuance from my insurance carrier.
I agree to assist with insurance verification if needed.
I am responsible for understanding my insurance benefits.

PATIENT CONSENT

I have read and understand the above and agree to all terms.

Print Name: _____ Date: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

SCARLETT SKY WELLNESS MASSAGE, P.C.

36 Hempstead Turnpike, Farmingdale, NY 11735
516-755-5855

CREDIT CARD AUTHORIZATION FORM

Patient Name: _____ DOB: _____

Phone: _____

Cardholder Name (if different): _____

Billing Address: _____

City/State/Zip: _____

Card Type: ☐ Visa ☐ MC ☐ Amex ☐ Discover

Card Number: _____

Exp Date: _____ / _____ CVV: _____

Amount to Charge: $_____

Purpose (check all that apply):

☐ Massage / Wellness Services

☐ Deductible or Co-Insurance / Balance

☐ Late Cancellation / No-Show Fee ($75)

☐ Other: _____

AUTHORIZATION

I authorize Scarlett Sky Wellness Massage, P.C. to charge my credit card for the amount listed above and any applicable charges incurred for services rendered, balances due, or missed appointment fees in accordance with office policies.

I certify that I am an authorized user of this card and agree not to dispute charges that comply with this authorization. I understand I am financially responsible for all charges incurred.

Cardholder Signature: _____

Print Name: _____ Date: _____

Office Use Only: Staff Initials: _____

Patient Intake

Personal Information

Name: _____ Email: _____

Phone (Cell): _____ Phone (Home): _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Occupation: _____ Emergency Contact: _____

Emergency Contact Phone: _____

The following information will be used to help plan a safe and effective treatment program.

Please answer the questions to the best of your knowledge.

Date of Initial Visit: _____ Chief Complaint(s): _____

Have you experienced these symptoms before? Yes ☐ No ☐

Are you currently working? Yes ☐ No ☐ if no, when was your last date worked? _____

If yes, any restrictions? _____

Have you ever had surgery? Yes ☐ No ☐

If yes, Type of Surgery: _____ Date of Surgery: _____

Have you received any medical care/treatment for your current condition/injury? Yes ☐ No ☐

If yes, please explain: _____

Have you had a professional medical massage before? Yes ☐ No ☐

If yes, was it covered by insurance? Yes ☐ No ☐

Have you had acupuncture treatment? Yes ☐ No ☐

Do you have any difficulty lying on your front, back, or side? Yes ☐ No ☐

If yes, please explain: _____

Do you have any allergies? Yes ☐ No ☐

If yes, please explain: _____

Do you have sensitive skin? Yes ☐ No ☐

Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐

If yes, please describe: _____

Do you perform any repetitive movements in your work, sports, or hobby? Yes ☐ No ☐

If yes, please describe: _____

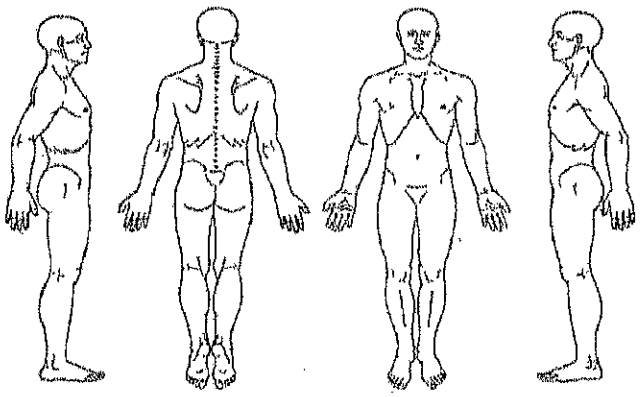
Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

_____

Pain Scale

1 2 3 4 5 6 7 8 9 10

Please denote your pain levels on the above scale, circling the number for your current pain level and putting an 'X' through the number where you would rate your pain when it's at its worst.



Circle any specific areas you would like the treatment team to concentrate on during your sessions.

How would you characterize your pain(s)? (Check all that apply)

☐ Sharp ☐ Stabbing ☐ Dull ☐ Aching ☐ Burning ☐ Numb/Tingling ☐ Spasm ☐ Stiff ☐ Radiating

Are there any activities that are made more difficult by your pain/injury? (i.e., lifting, pushing, etc.)

_____

Are there any areas that you are uncomfortable being touched/massaged during your treatments?

_____

Medical History

Are you currently under medical supervision? Yes ☐ No ☐

If yes, please explain: _____

Are you currently taking any medication? Yes ☐ No ☐

If yes, please list: _____

Please check any condition listed below that applies to you:

☐ Contagious skin condition
☐ Open sores or wounds
☐ Easy bruising
☐ Recent surgery
☐ Phlebitis
☐ Artificial joint
☐ Current fever
☐ Allergies/sensitivity
☐ High or low blood pressure
☐ Varicose veins
☐ Headaches/migraines
☐ Diabetes
☐ Back/neck problems
☐ TMJ
☐ Tennis elbow
☐ Other: _____

☐ Recent accident or injury
☐ Deep vein thrombosis / blood clots
☐ Joint disorder / rheumatoid arthritis / osteoarthritis / tendonitis
☐ Osteoporosis
☐ Epilepsy
☐ Sprains/strains
☐ Swollen glands
☐ Heart condition
☐ Circulatory disorder
☐ Atherosclerosis
☐ Cancer
☐ Decreased sensation
☐ Fibromyalgia
☐ Carpal tunnel syndrome
☐ Pregnancy (if yes, how many months?) _____

Please explain any condition that you have marked above:

_____

Is there anything else about your health history that you think would be useful for your treatment team to know to plan a safe and effective treatment plan for you?

_____

HIPPA Patient Consent Form Authorization For Release Of Medical Records & Reports

Patient Name: _____
Date of Birth: ____ / ____ / _____

The Department of Health and Human Services established a "Privacy Rule" to help ensure that personal health information is protected for privacy. This Privacy Rule also created a standard for healthcare providers to obtain their patients' consent for the use and disclosure of health information related to treatment, care, and payment for healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical information and will do everything we can to protect it. We take reasonable precautions to safeguard your privacy. When necessary and appropriate, we only provide the minimum required information to those we believe need it for your care, treatment, payments, and/or healthcare operations, in order to provide you with the best possible quality of care.

I hereby authorize all healthcare providers, physicians, hospitals, clinics, institutions, medical facilities, mental health clinics, mental health hospitals, and pharmacies to release all existing medical records and information related to the above-named patient's:

- Medical care and treatment and Physical/medical condition
- Medical expenses as revealed by your observation or treatment of past, present, and future

This includes but is not limited to:

- New York Wellness Massage, PC
- Lotus Massage Wellness, PC
- A to Z Medical, PLLC
- Exact Medical, PLLC
- Starwood Acupuncture, PC
- Ubase Life Acupuncture, PLLC
- Kyrum Acupuncture PC

By signing this form, you consent to our use and disclosure of your protected health information for the following purposes:
A) Treatment, payment, and healthcare operations to all applicable medical providers, including direct or indirect treatment (e.g., release of radiographs, imaging, and/or treatment plans by referring physicians)
B) Obtaining payment from third-party payers (e.g., insurance companies)
C) The day-to-day healthcare operations of our practice(s)

You have the right to refuse consent to the use or disclosure of your personal health information, but such refusal must be submitted in writing. Under this law, we have the right to refuse treatment if you choose not to disclose your personal health information (PHI). If you initially provide consent, you may later request to revoke all or part of your PHI consent. Such revocation will not affect any disclosures made in reliance on your prior consent.

This practice complies with the Health Insurance Portability and Accountability Act (HIPAA).
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

The patient understands that (Please initial each item):

_____ Protected health information may be disclosed or used for treatment, payment, or health care operations.

_____ The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.

_____ The Practice reserves the right to change the Notice of Privacy Practices.

_____ The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.

_____ The patient may revoke this Consent in writing at any time and all future disclosures will then cease.

_____ The Practice may condition receipt of treatment upon the execution of this Consent.

Patient Name _____

Signature _____

Date _____

Designation of Authorized Representative

Member's name (please print):	Date of birth:

Member's street address:

City:	State:	ZIP code:

Designated representative's address: 36 Hempstead Turnpike

City: Farmingdale	State: New York	ZIP code: 11735

Provider:	Date(s) of service or proposed service:

I _____, am appointing

Print the name of the member who is receiving the service or supply:

Print the name of the person/organization who is being authorized to act on the member's behalf:

To act on my behalf as my authorized representative for (check all that apply)

☐ A complaint ☐ An appeal

☐ Documents from UnitedHealthcare regarding the above-noted service or proposed service

I understand and agree that:

- This authorization is voluntary
- My health information may be disclosed to my authorized representative and may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information
- I may not be denied treatment, payment for health care services, enrollment or eligibility for health care benefits if I do not sign this form
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation
- This authorization will expire 2 years from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of member or approved party:	Date:

If person signing this authorization is not the member, describe relationship to the member (i.e., parent, legal representative):

United Healthcare

Informed Consent for Acupuncture Treatment & Care

I hereby request and consent to performance of acupuncture treatment and other Oriental Medicine procedure(s) by the below named licensed acupuncturist and/or other licensed acupuncturists to now or in the future treat me while employed by or working or associated with serving as a back-up for the treating acupuncturist named below including those working at the office or any other office or clinic.

I understand that Acupuncture therapy is not a substitute for medical examination and diagnosis. It is recommended that I see a medical doctor for any physical ailment for which I may seek acupuncture treatment.

I fully understand that Acupuncture therapy is a safe method of treatment. I have been informed that acupuncture therapy may involve the insertion of several sterile and disposable needles into the skin and realize that some bruising, soreness and superficial bleeding are occasional occurrences near the needle sites that last for a few days.

Cupping bodywork therapy is an adaptation of an ancient technique; the purpose of this technique is to promote health and healing by loosening soft tissue and connective tissue, scarring and adhesion moving stagnation and increasing lymphatic flow and circulation. This therapy utilizes silicone or plastic cups and a vacuum pistol to create suction on the body surface. These cups are moved over the skin using gliding, shaking, popping and rotating techniques while gently pulling up on the cup, or may be parked for a short time to facilitate joint mobilization or soft tissue release. Suction reaches deep into soft tissue, attachments and organs. Another benefit is to pull toxins and inflammation from the body to the surface of the skin where the lymphatic system can more readily eliminate them.

Potential Reactions to cupping are temporary and may include:
- Discoloration is due to toxins and old blood being brought to the surface.
- Post tenderness: usually less than experienced from deep tissue work.
- Warmth and/or Itching: increases vaso-dilation and/or inflammation brought to the surface.
- Decreased Blood Pressure: due to vaso-dilation and/or nervous system sedation.

I understand that the clinical and administrative staff can review my medical records and all reports, but all my records will be kept confidential and will not be released without my written consent.

I have read or have had read to me, the above consent. I also had the opportunity to ask questions about this consent, and by signing below I agree to the above named procedures.

I intend this consent form to cover the entire course of treatment for my present condition and any future condition(s) for which I may seek treatment.

Visit Limit For Massage Therapy & Acupuncture Services

Acknowledgement of Receipt/Responsibility of NYSHIP clients

Effective July 1, 2023:

There will be a maximum of 20 visits per calendar year allowed under the NYSHIP EMPIRE PLAN. Acupuncture Services providers are subject to a maximum of 20 visits per calendar year.

The deductible and 20 percent coinsurance will apply.

I have read, acknowledge, and understand the above terms. In the event I receive these services at additional providers, those visits will be counted as part of my 20-visit maximum, and I will be solely responsible for payment in full for each therapy session in excess of the 20-visit maximum allowable outlined by the NYSHIP EMPIRE PLAN.

Patient Name _____

Patient Signature _____ Date _____

Massage Therapy Client Consent Form

In keeping with the Health Care Consent Act, it is my choice to receive massage therapy. I understand that an assessment is required from time to time to determine suitable treatment for me. The treatment can be interrupted at times in order to facilitate communication and for the massage therapist to obtain feedback from me, I also understand that the information I provided is confidential and it shall not be released without my permission. I am aware that the information I provided can be used in a team or clinical setting for educational or treatment purposes.

I am aware that the massage therapist and the clinic who provide massage therapy service are not responsible for any lost, stolen or damaged articles. I have read through and agreed to the above conditions. I also have had the chance to have all of my questions answered before agreeing to and receiving massage therapy treatments. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis, and I should see my health care provider for those services. I agree to keep the massage therapist updated on any changes to my health condition and understand that there shall be no liability on the therapist's part should I fail to do so.

Client Name: _____

Client Signature:_____

Date:_____

Massage Therapy Consent To Treat A Minor

I, _____, parent/guardian of _____, have read and understood the aforementioned statements regarding massage therapy. I authorize Lotus Wellness Massage PC and their therapist(s) to provide massage therapy and body work to my child or dependent.

Client Name: _____

Client Signature:_____

Date:_____

Visit Limit For Massage Therapy & Acupuncture Services

Acknowledgement of Receipt/Responsibility of NYSHIP clients

Effective July 1, 2023:

There will be a maximum of 20 visits per calendar year allowed under the NYSHIP EMPIRE PLAN. Acupuncture Services providers are subject to a maximum of 20 visits per calendar year.

The deductible and 20 percent coinsurance will apply.

I have read, acknowledge, and understand the above terms. In the event I receive these services at additional providers, those visits will be counted as part of my 20-visit maximum, and I will be solely responsible for payment in full for each therapy session in excess of the 20-visit maximum allowable outlined by the NYSHIP EMPIRE PLAN.

Patient Name _____

Patient Signature _____ Date _____

Trigger Point & Nerve Block Therapy

Trigger Point, Joint and Nerve Block Injection therapies are considered surgical procedures that treat localized areas of muscle, joint, ligament, tendon and nerve inflammation and impingement which cause pain, restrict range of motion, and prevent proper blood circulation. This form of therapy is performed by licensed medical providers using ultrasound to guide the injections directly to the affected area(s).

These therapies are free of narcotics and steroids, with minimal side effects, no contraindication with any medication, and safe for weekly use in pain management routines as well as preventative care.

Most patients feel no adverse effects at all. Those that do most commonly experience injection site irritation and numbness, which generally resolves within a few hours. Occasionally, patients can experience lightheadedness due to lidocaine/bupivacaine exposure. Uncommon side effects may include localized infection, cellulitis, abscess formation.

As with all medication there may be rare side effects including but not limited to fever, shortness of breath, rapid/slow heartbeat; feeling anxious/confused may be a sign of a more serious condition. Signs of an allergic reaction include severe itching of skin, conjunctivitis, runny nose, swelling of upper/lower lips, cheeks, and larynx. Seek immediate medical attention if you experience any of these symptoms.

I have read and understood the risks associated with the surgical procedures of trigger point and nerve block therapy and consent to weekly treatment as deemed appropriate by the practice providers. This authorization is valid until revoked in writing.

Patient Name _____

Patient Signature _____ Date _____

Witness Name: _____

Witness Signature: _____