Structural Integration – Inspired by the teachings of Dr. Ida P. Rolf Form version: Mar/6/2017

Personal History Form

(Confidential)

Name: _____ Home Ph. (Eve) (_____) _____ - _____

Street: _____ Work Ph. (Day) (_____) _____ - _____

City/State/Zip: _____ Mobile/ Cell Ph.(_____) _____ - _____

D.O.B. _____ Age _____ Sex: M / F Ht. _____ Wt. _____

Occupation: _____ Email:_____

How did you hear about us? **Can we inform you of new info & opportunities?** _____

Healthy Habits /Activities	
Major physical injuries / disabilities / concerns / Physical discomforts (note specific stressors)	
Therapy goals (be specific)	

Do you wear contacts and / or dental appliances?	Yes	No		Ever been in manual or physical therapy? (Past or present)	Yes	No
Do you wear arch supports and / or depend upon surgical implants?				*(**Men**/Women) Sexual difficulties,* *(Women) Menstruation, or other difficulties?*		
Are you now under treatment / or medication?				*(Women) Are you pregnant?* *(Women) Do you use an IUD?*		
Comments:				Comments:		

Consulting Physicians and other Health Care Team Providers: (Name, Address, City, State, Zip, Phone, Fax, Optional Comment)

_____

_____

_____

Regarding my dependent minor, or me, I give my manual therapist permission to consult with listed health care providers and/or the relevant services of the Conscious Health Collaborative regarding health, treatment, billing, and scheduling logistics. I contract to participate fully as a member of this health care team, making sound choices regarding treatment based upon my experience of information and suggestions provided by this health care team. It is my choice to receive manual therapy, and I give my consent to receive treatment. I agree to participate in the self-care program we select and promise to inform my practitioner of changes in health or any time I feel well-being is compromised.

Date: _____ Signature: _____

Disclosure, Application and Consent for Massage Therapy and the Original Rolf Method of Structural Integration

Expectations:

I fully understand that the purpose of Structural Integration (SI) is to balance and align the physical body so that it is supported and maintained by gravity in three-dimensional space. This is done through direct tissue manipulation and education so that greater economy and freedom of body movement is achieved. Massage therapy is designed to relax and release muscular tension.

Further, I understand that any relief of emotional symptoms is coincidental in the organization of the total human being and is not the basic goal of Structural Integration or massage therapy.

Health and Well-Being Concerns:

I understand Structural Integration and massage therapy is not involved with the treatment of disease of any kind, nor does it substitute for medical diagnosis or treatment when such attention is needed.

The Practitioner of Structural Integration and massage therapy does not treat, prescribe or diagnose an illness, disease, or any other physical or mental disorder of the person. Nothing said or done by the Structural Integration Practitioner should be misconstrued to be such.

Boundaries:

I understand it is necessary for the Structural Integration Practitioner to do a visual structural assessment and to touch my body in order to assist me in establishing balance and alignment.

I give Jack Boyd my permission and consent to do all those things necessary in helping me establish balance and alignment, including, but not limited to touching my body. I give the Practitioner full privilege and license to work on my body in such a way as to restore and establish balance and alignment. *Therefore, if I experience pain at any time during a session, I will inform the Practitioner immediately so that the pressure may be adjusted to my level of comfort. Also, if at any time I feel unsafe, I will immediately inform the Practitioner, and ask that he shall stop.* The therapist shall honor all such requests immediately. *I shall wear cotton underwear appropriate for visual structural assessment for SI.*

Commitments:

Because Structural Integration and massage therapy should not be done under certain medical conditions, I affirm that I have stated all my known medical conditions and have answered all questions honestly. I agree to keep the Practitioner updated as to any changes of my medical profile. I understand that there shall be no liability on the Practitioner's part, shall I forget to do so.

I will see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware of, if needed.

I give my manual therapist permission to consult and share information with my health care providers and relevant services of the Conscious Health Collaborative regarding my health, treatment, billing, and scheduling logistics. I contract to participate fully as a member of my health care team, making sound choices regarding my treatment based upon my experience of information and suggestions provided by my health care team. It is my choice to receive manual therapy, and I give my consent to receive treatment. I agree to participate in the self-care program we select and promise to inform my practitioner of changes in my health or any time I feel my well-being is compromised.

Signature: _____ Date: _____

Expanding Our Inner Space

Structural Rolf Therapy Integration
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FEE SCHEDULE

Structural Integration - $97 per session (normally taking 90 minutes.)
Massage Therapy - $70 per hr., $90 per full body session (90 minutes.)

These rates are broken down per Insurance CPT codes as follows:

CPT Code	Description	Fee Schedule *
99202 or 97001	New Client – 1st Office Visit Limited (15-30 min.)	$ 42
99212	Follow-up Office Exams	$ 23
97124	Massage, including effleurage (each 15 min. unit)	$ 25
97139 or 97140	Structural Integration (each 15 min. unit)	$ 25

* Add $5.00 for Visa or MC credit card processing

1. PAYMENT POLICIES:

Payment is expected via cash, personal check, or credit (Visa or Master Card) at the time services are provided under any discounts. A valid credit card number on file may be required to guarantee payment.

Insurance Billing: With my assistance, you will be responsible for billing your insurance company except for companies where I have approved my listing as a preferred provider. This includes insurance billing for private health, personal injury, and/or workman's compensation.

All accounts not paid in full within 90 days from date of service will be charged interest. Interest rates are 12% annually and are charged at 1% monthly. Interest is calculated on the principal amount; interest is not compounded.

2. OFFICE POLICIES

Cancellations: Cancellations or rescheduling must be made 24 hours in advance of the scheduled appointment time. Payment in full is required for the full time originally scheduled, if cancellation or rescheduling is done in less than 24 hours, or if a full session cannot be given due to tardiness. This charge will be waived if a replacement can be found for your appointment time. Your insurance company will not be charged for your missed appointment; you will be responsible for payment out-of-pocket. Emergency cancellations will receive special consideration.

The following credit card guarantees payment if necessary: Type: _____ (Visa or MC only please)

Number: _____; Expiration: _____; Security: _____; Billing Zip: _____;

Right of Refusal: I reserve the right to refuse service to anyone. This includes but is not limited to anyone who requests treatment or services that are outside my scope of practice. I will exercise this right if anyone arrives for treatment under the influence of alcohol or recreational drugs; I reserve the right to charge for the session time, whether or not services were rendered.

I have read the policies stated above and agree to abide by them.

Client Signature: _____ Date: _____