

# Expanding Our Inner Space



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Asheville Structural Integration LLC  
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Welcome to Structural Integration.

Thank you for committing to a session at Asheville Structural Integration LLC. I am very excited at this opportunity to become an integral member of your health care team. Your experience can be more fulfilling by attending to the following:

1. Before your session, please drink plenty of water and eat no more than moderately.
2. To maximize your session time, please bring the following forms with your information completed as well as you can.

Click on each link, print the form, and come back to this browser window tab for the next form.

(You may have to close the form's window tab to come back here to this browser window tab for the next form.)

[Click Here for History Form](#)

[Click Here for Application Consent Form](#)

[Click Here for Fees and Policies](#)

3. Directions to the office are below. Parking is free in our lot.
4. Please arrive a few minutes early if possible and enjoy your quiet time in our lobby. Before your session you are welcome to use the restroom, off our lobby. Please text me at 828-230-9218 so that I know when you arrive, and I will meet you in the lobby.

I am committed to your experience being informative, productive, and enjoyable. Please call if you have any questions. I look forward to meeting you.

Warmly,

Jack Boyd, L.M.B.T.#3925  
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[JBoyd.ASI@gmail.com](mailto:JBoyd.ASI@gmail.com)

P.S. You can now check my schedule from my website in real-time to see what is available.

Just click on the following button to book your next appointment yourself  or give me a call at 828-230-9218.

DIRECTIONS: From Asheville **I-40 exit 53A** to Charlotte Hwy (Alt 74), turning southeast toward Reynolds and Fletcher. Proceed straight for 1 and 1/2 miles until the traffic light for Ingles and Eastwood Village at 4 Olde Eastwood Village Blvd. We are upstairs in suite 207 E, entrance right next door to the Great Wall of China. Text me when you arrive so I know you are in the lobby.

**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?			<i>(Men/Women) Sexual difficulties, (Women) Menstruation, or other difficulties?</i>		
Are you now under treatment / or medication?			<i>(Women) Are you pregnant? (Women) Do you use an IUD?</i>		
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 and Asheville Structural Integration LLC 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 Asheville Structural Integration LLC, and 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: \_\_\_\_\_

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## FEE SCHEDULE

- Structural Integration - \$117 cash per session (normally taking 90 minutes.)
- Massage Therapy - \$90 cash per hr., \$117 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 – 1 <sup>st</sup> Office Visit Limited (15-30 min.) - If billing invoice required.	\$53.00
99212	Follow-up Office Exams - If billing invoice required	\$28.00
97124	Massage, including effleurage (each 15 min. unit) /billed invoice	\$30.00
97139 or 97140	Structural Integration (each 15 min. unit) /billed invoice	\$30.00

\* 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: \_\_\_\_\_