movementplus

Advanced Institute of
Physical Therapy

MASSAGE THERAPY INTAKE FORM

PERSONAL INFORMATION

Name: _____ DOB: _____

Address: _____

_____ _____ _____

City State Zip code

Cell Phone: _____ Home Phone: _____ E-mail: _____

Emergency contact/relationship: _____ Phone: _____

Primary Physician: _____ Occupation: _____

MEDICAL INFORMATION

Put "X" if you have a history of any of the following

___ *Cancer*	___ *Blood clots/Circulatory Issues*	___ *Hypo/hypertension*	___ *Stroke*
___ *Diabetes*	___ *Joint replacement*	___ *Renal Dysfunction*	___ *Heart Attack*
___ *Neuropathy*	___ *Plantar Fasciitis*	___ *Fibromyalgia*	___ *Osteoporosis*
___ *Sciatica*	___ *Arthritis*	___ *Fractures*	___ *TMJ*
___*Eczema*	___ *Psoriasis*	___ *Pregnancy_____weeks*	

Put "X" if you have experienced any of the following in the last 6 months.

___ *Back Pain: Upper Mid Low*	___ *Neck Pain*	___ *Numbness/Tingling*	
___ *Shoulder Pain*	___ *Arm Pain*	___ *Wrist Pain*	___*Strain/Sprain*
___ *Leg Pain*	___ *Knee Pain*	___ *Ankle Pain*	___*Headaches/Migraines*

Are you currently taking any medications? ___ Yes ___ No

If yes, please list medications: _____

When was the last time you received body work?

_____

What are your goals/expectations for this massage?

_____

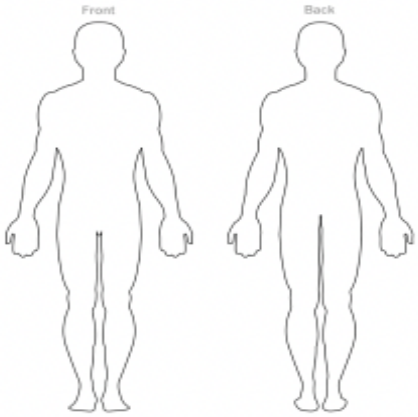
Do you have any allergies or sensitives to lotions or oils?

_____

Do you have any interest in the following? Put "X" that apply

__ Cupping ___ Aromatherapy ___ Prenatal Massage

*Please circle any areas of discomfort.



By signing the below, I agree to the following,

I have completed this form to the best of my knowledge and agree to inform the therapist if any of the information above changes at any time.

Signature: _____ Date: _____

1 (808) 600-9148
info@movementplus.com
movementplus.com

Aiea
98-1005 Moanalua Road,
SPC 410 Aiea, HI 96701

Honolulu
1401 S. Beretania St., Ste
888 Honolulu, HI 96814

Waipahu
94-216 Farrington Hwy.,
Ste A-102 Waipahu, HI 96797

Credit Card On File Policy

To Our Patients:

At the time of registration, we will request your credit card information. Your credit card numbers will be encrypted and stored securely. If you have ever stayed in a hotel or rented a car, you are familiar with the concept of having a credit card on file. Your credit card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due. As of May 1, 2025, Movement Plus Physical Therapy has adopted a Credit Card on File Policy.

Once we receive your Explanation of Benefits (EOB) (what the insurance company will pay towards your visit), we will wait 30 days to allow you time to pay the balance on your account. If your balance is not paid, your credit card will be charged for the outstanding balance that is your responsibility. Co-pays must be paid at the time of visit. If you have any questions about this payment method, please do not hesitate to call our **Billing Office** at **808-600-9148.**

How does credit card on file benefit me?
Using credit card on file, you will be able to:

- Pay balances and co-pays conveniently
- Make payments automatically using your credit card of choice
- Avoid writing checks to pay bills by mail
- Receive notifications and receipts sent via email

Please note that all of your rights with respect to the use of your credit card will remain in effect. This new policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment.

Your credit card on file can be used for the following reasons:
-Visit payments not collected from you at the beginning of the visit
-No show or late cancellation charges
-Insurance discrepancies
-Outstanding balance greater than 31 days past due

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Authorization Form

****Please do not send this form over email. Bring this form with you at your first appointment****

Credit Card Type (circle) Visa MasterCard Discover Amex

Credit Card Number | Exp Date | CVV/CVC | Name as it appears on card

Billing Address | City | State | Zip

Phone Number | Email

Patient Name | DOB | Patient Name | DOB

Patient Name | DOB | Patient Name | DOB

I authorize Movement Plus Physical Therapy (MPPT) to charge the credit card above per the terms of this policy. This authorization shall remain in effect until MPPT has received written notification from me of its termination.

Signature | Date

The information will be immediately uploaded into our payment system, a highly secured and certified. All card numbers are encrypted and decryption keys are stored on separate machines from the card data.

The credit card number and CVV/CVC on this paper authorization will be redacted prior to uploading to the patient's medical records. Once a copy of the authorization has been uploaded, this paper authorization will be destroyed.

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