Massage Spa Massage Intake Form

PERSONAL INFORMATION

Client Name: _____ **E-mail Address:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone numbers (c):_____ **(h):** _____ **(w):** _____

Occupation: _____ **Date of Birth:** _____

How would you like to be notified of your appointments?

❍ telephone ❍ e-mail ❍ mobile text message, list carrier name:_____ (standard carrier rates may apply)

May we leave a phone message with another person at the above phone number(s)? ❍ Yes ❍ No

How did you hear about Massage Spa?: _____

MEDICAL AND HEALTH INFORMATION

Emergency contact name and telephone number:_____

Please check all that apply:

❍ headaches	❍ neck pain	❍ back pain	❍ jaw clenching / teeth grinding
❍ leg / knee pain	❍ seizures	❍ bruise easily	❍ high blood pressure
❍ varicose veins	❍ wear eye contacts	❍ diabetes	❍ fibromyalgia

❍ **numbness / tingling, if so: where?** _____

❍ **active cancer (if so please have medical release available): where?** _____

Do you have any allergies and/or skin sensitivities? ❍ Yes ❍ No

If yes, please list:_____

Our lotion products may contain nut oils. Are you allergic to nut or nut products? ❍ Yes ❍ No

If yes, please list the types of nuts: _____

Accidents, injuries and/or surgeries in the last two years? Please list, including date of occurrence:

_____

_____

Please list any conditions or side-effects you have and/or medications you are taking associated with these conditions:

_____

Are you pregnant or trying to become pregnant? ❍ Yes ❍ No

If yes, how many weeks: _____ **Approximate Due Date:** _____

Postpartum two years or less? ❍ Yes ❍ No

Are there any additional medical issues we should know about? _____

By signing below, I agree that I have read and understand the following:

I understand that massage is not a replacement for medical care and that no medical diagnosis will be made. Any illicit or sexually suggestive comments or actions made by me will result in immediate termination of the session and I am responsible for full payment.

Cancellation Policy: Should I cancel or miss an appointment with less than 24 hours notice, I authorize this Massage Spa, PLLC to charge my VISA/ Mastercard / American Express / Discover Card for $25 for 30 minute session, $40 for 60 minute session and $52 for 90 minute session.

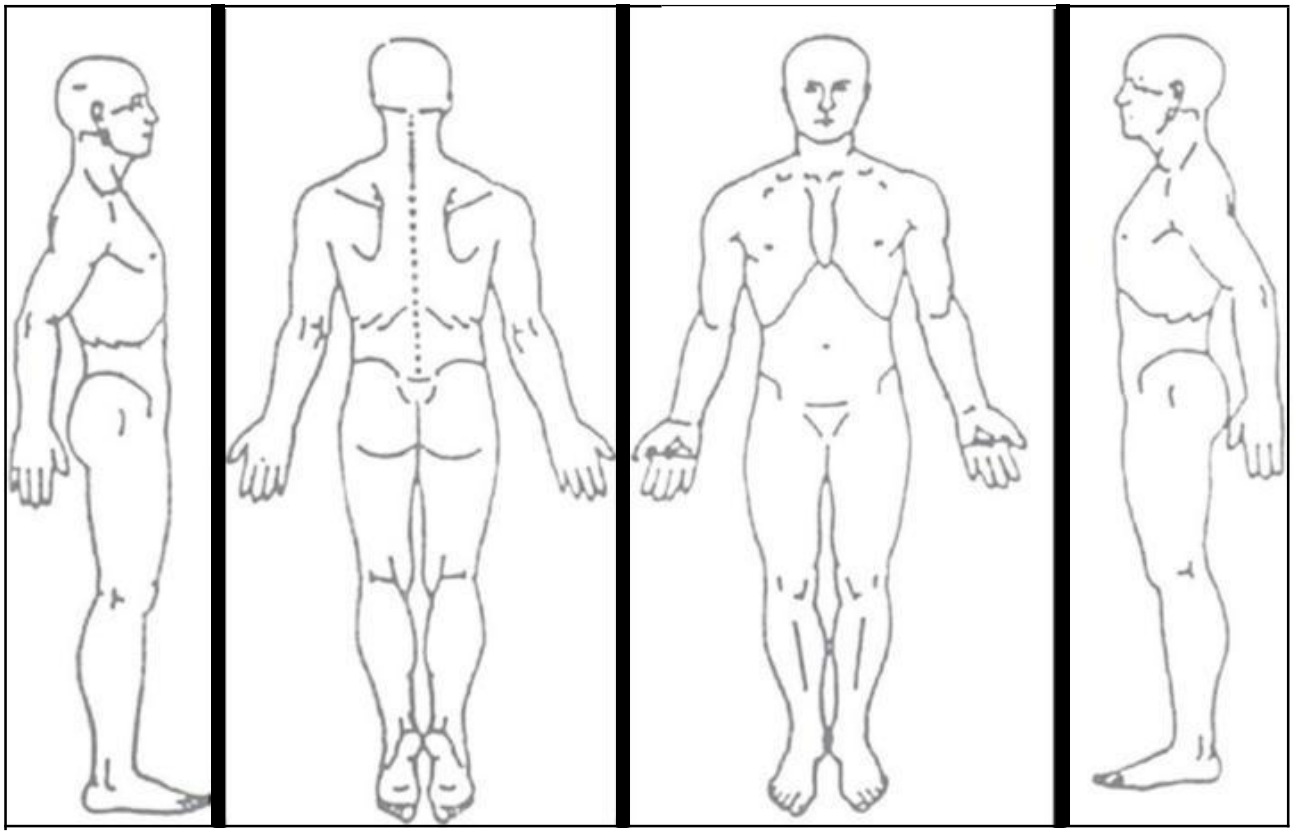
E-mail Policy: We will use your e-mail address and phone number for appointment reminders, promotions and news from Massage Spa, PLLC. Your privacy is important to us. We will not sell, rent, or give your name or address to anyone. To unsubscribe, or to receive less or more information, you can select a link at the bottom of every e-mail.

Non-Solicitation Policy: I will not solicit, recruit, or encourage any person employed by Massage Spa, PLLC for employment or the provision of services outside of the spa.

____**(Initial Here)I acknowledge that I have received Notice of HIPAA Privacy Practices.**

Signature:_____ **Date:**_____ **Therapist Initials:**_____

Please indicate what type massage you are seeking.	**__Swedish __Deep Tissue** **__ Sports Massage __ Relaxation** **__ Therapeutic __ Prenatal**
Massage Spa, PLLC does not perform breast massage.	
At Massage Spa, PLLC we do not perform any massage without proper draping. "Draping" means that your body will be modestly covered by a sheet during the massage.	
Conduct Rules: If you the client is uncomfortable for any reason, the client may ask the therapist to cease the massage, and the therapist wil do so.	As therapist,I also reserve the right to end a session in the event of any sort of abusive behavior from the client. If client misbehavior should result in an abbreviated session, the client will be expected to render full payment.
Please Mark Accordingly: Mark parts of your body that you are having tension or the areas to be avoided during the session. Please include details of Indications or any contraindications.	**To be completed:** √ **Place an X any areas to be avoided** √ **Place a CIRCLE on areas that need extra attention.**



I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy. I understand that massage therapy is not a substitute for medical treatment or medications and that it is recommended that I concurrently work with my Primary Caregiver for any conditions that I may have.

I have read and agree to the above.

Client Signature:	Date:
LMT Signature: License #	Date:

COVID-19 Health Information & Informed Consent

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus - type symptoms? Yes ☐ No ☐

4. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐

Location: _____

5. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐

8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

Consent for Use and Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you can request to be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

APPOINTMENT REMINDERS AND HEALTH CARE INFORMATION AUTHORIZATION

Your massage therapist and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not available, a message will be left on your answering machine or with the person answering the phone. By signing this form, you are giving us authorization to contact you with these reminders and information and to leave messages on your answering machine or with individuals at your home or place of employment. You also are authorizing the use of communication through email using the email you provide in the demographic section of this paperwork.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your revocation. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. However, we will not be authorized to call you regarding appointments, treatment, or claim status information.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.

This notice is effective as of today. This authorization will expire seven years after the date on which you last received services from us.

I have read both the above policies and agree to its terms. I am also acknowledging that I can, upon request receive a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

Client Signature:	Date:
LMT Signature: License #	Date: