



THERAPEUTIC MASSAGE AND MOVEMENT  
715 HILL ST. SUITE 122 MADISON, WI 53705  
[www.pbmad.com](http://www.pbmad.com) 608-285-2124

## Massage Therapy and Bodywork Therapy Informed Consent

I, \_\_\_\_\_ (client), understand that therapeutic massage and movement education provided by my Premier Bodywork LLC (WI License #12703-146) practitioner(s) is compliant with all applicable Wisconsin Statutes and Laws. Section 460.01(4) states: "Massage therapy" or "bodywork therapy" means the science and healing art that uses manual actions and adjunctive therapies to palpate and manipulate the soft tissue of the human body in order to improve circulation, reduce tension, relieve soft tissue pain, or increase flexibility. "Massage therapy" or "bodywork therapy" includes determining whether manual actions and adjunctive therapies are appropriate or contraindicated, or whether a referral to another health care practitioner is appropriate. "Massage therapy" or "bodywork therapy" does not include making a medical, physical therapy, or chiropractic diagnosis.

I have received a copy of Premier Bodywork LLC's policies, I understand them and agree to abide by them.

I have informed my Premier Bodywork LLC practitioner(s) of all my known physical conditions, medical conditions and medications, and I will keep the practitioner(s) I work with updated on any changes.

By signing this form, I confirm my consent for my practitioner(s) to treat me with massage therapy and intend this consent to cover the treatments discussed with me, including such additional assessments, examinations and techniques which may be recommended by my practitioner(s). I further understand that I have the legal right to withdraw my consent, either verbally or in writing, at any time, for any reason.

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Client Signature

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Date



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## Cancellation Policy

Due to scheduling complexity, it can be difficult to fill an appointment time opened by a cancellation.

If you must cancel your appointment, please do so at least 24 hours in advance by calling or texting 608-285-2124 OR email [robb.seal@pbmad.com](mailto:robb.seal@pbmad.com) and leaving a message. **Your cancellation isn't complete until you receive a confirmation reply from Premier Bodywork.**

Full payment will be expected for appointments missed or canceled less than 24 hours before your scheduled session time.

Exceptions may be made in the event of illness or emergency, at management's discretion. Please notify us as soon as possible.

If, for any reason, we must cancel an appointment within 24 hours before your scheduled session time, we will notify you at your callback number or other preferred method of communication and attempt to reschedule your appointment at the earliest convenience. As an apology to you, the rescheduled appointment will be upgraded with an additional 30 minutes of service.

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Client Signature

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Practitioner Signature



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## **Notice of Privacy Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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### 1. Our pledge regarding medical information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive in your work with us. This record enables us to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways your medical information may be used.

### 2. Our legal duty

The law requires us to:

- a) Keep your medical information private.
- b) Give you this notice describing your legal duties, and your rights regarding your medical information.
- c) Follow the terms of this notice that is now in effect.

We have the right to:

- a) We may need to change our policies at some time in the future. Before we make significant changes in our policies, we will provide you with a revised copy of this notice. The terms of the new notice will be effective for all medical information that we keep, including information previously created or received before the changes.
- b) You may request a copy of this notice at any time.

### 3. Use and disclosure of your medical information

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. You may revoke written authorization at any time by writing to us.

- a) For treatment: We may use medical information about you to provide you with treatment.
- b) Notification: We may use or disclose your medical information to notify or help notify a family member or personal representative in the event you become ill or

need assistance. In this event, we will share information about your location and general condition.

c) Court Orders and Judicial and Administrative Proceedings: We may be required to disclose your medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances.

d) Research in limited circumstances: medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

4. Your individual rights

You have a right to:

a) Look at or get copies of your medical information. You may be required to make your request in writing, using the appropriate form(s).

b) Receive a list of instances where we have disclosed health information about you for reasons other than treatment (for example, a subpoena).

c) Request that we place additional restrictions on our use or disclosure of your medical information. We will consider your request, but are not obligated by law to agree to the restrictions.

d) Request that we change your medical information. If you believe that information within your records is incorrect or if important information is missing, you have a right to request that we correct the existing information or add the missing information.

e) Request confidential communications. You have a right to receive confidential communications containing your health information. Your request that we communicate your medical information to you by different means or at different locations may be required in writing.

f) Have a paper copy of this notice.

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Questions and Complaints

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us as listed here: HIPAA Privacy Policies Form, Premier Bodywork LLC, 715 Hill St. Suite 122 Madison, WI 53705 or phone 608-285-2124. You also may send a written complaint to the U.S. Department of Health and Human Service. Visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for further information.

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I have read and understand the above policies:

\_\_\_\_\_  
your name printed

\_\_\_\_\_  
your signature

\_\_\_\_\_ (date)

Premier Bodywork LLC, Robert L Seal Owner

\_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Email \_\_\_\_\_  
Occupation \_\_\_\_\_  
Emergency Contact (name and phone number):  
\_\_\_\_\_



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**Personal medical history (list and explain dates and treatments received):**

Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Accidents: \_\_\_\_\_  
\_\_\_\_\_

Illnesses or Other Medical Conditions: \_\_\_\_\_  
\_\_\_\_\_

Briefly describe your family's medical history \_\_\_\_\_  
\_\_\_\_\_

**List musculoskeletal concern(s)/issue(s) in order of importance:**

Location \_\_\_\_\_ Severity \_\_\_\_\_ Frequency & Duration \_\_\_\_\_

Aggravating factors \_\_\_\_\_

Relieving factors \_\_\_\_\_

Treatment received \_\_\_\_\_ Outcome \_\_\_\_\_

Location \_\_\_\_\_ Severity \_\_\_\_\_ Frequency & Duration \_\_\_\_\_

Aggravating factors \_\_\_\_\_

Relieving factors \_\_\_\_\_

Treatment received \_\_\_\_\_ Outcome \_\_\_\_\_

Location \_\_\_\_\_ Severity \_\_\_\_\_ Frequency & Duration \_\_\_\_\_

Aggravating factors \_\_\_\_\_

Relieving factors \_\_\_\_\_

Treatment received \_\_\_\_\_ Outcome \_\_\_\_\_

Location \_\_\_\_\_ Severity \_\_\_\_\_ Frequency & Duration \_\_\_\_\_

Aggravating factors \_\_\_\_\_

Relieving factors \_\_\_\_\_

Treatment received \_\_\_\_\_ Outcome \_\_\_\_\_

Describe any conditions currently monitored by a Health Care Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications you are currently taking or have recently taken (include date of last use)\_\_\_\_\_

Describe your experience with therapeutic massage and/or bodywork\_\_\_\_\_

Allergies \_\_\_\_\_

**Daily Activities:** Work\_\_\_\_\_

Home & Family\_\_\_\_\_

Social/Recreational\_\_\_\_\_

What are your goals for receiving therapeutic massage and bodywork?\_\_\_\_\_

**Please check all conditions with a "C" (current), "P" (previous) or "F" (family):**

**General**

- \_\_\_\_\_ headaches
- \_\_\_\_\_ pain
- \_\_\_\_\_ sleep disturbances
- \_\_\_\_\_ fatigue
- \_\_\_\_\_ infections
- \_\_\_\_\_ fever
- \_\_\_\_\_ sinus
- \_\_\_\_\_ other

**Digestive & Elimination**

- \_\_\_\_\_ bowel dysfunction
- \_\_\_\_\_ gas, bloating
- \_\_\_\_\_ bladder/kidney
- \_\_\_\_\_ abdominal pain
- \_\_\_\_\_ other

**Endocrine System**

- \_\_\_\_\_ thyroid dysfunction
- \_\_\_\_\_ diabetes
- \_\_\_\_\_ other

**Nervous System**

- \_\_\_\_\_ head injury, concussion
- \_\_\_\_\_ dizziness, tinnitus
- \_\_\_\_\_ memory loss, confusion
- \_\_\_\_\_ numbness, tingling
- \_\_\_\_\_ sciatica, shooting pain
- \_\_\_\_\_ chronic pain
- \_\_\_\_\_ depression
- \_\_\_\_\_ other

**Reproductive System**

- \_\_\_\_\_ pregnancy
- \_\_\_\_\_ painful, emotional
- \_\_\_\_\_ menses
- \_\_\_\_\_ fibrotic cysts
- \_\_\_\_\_ other

**Muscles and Joints**

- \_\_\_\_\_ rheumatoid arthritis
- \_\_\_\_\_ osteoarthritis
- \_\_\_\_\_ osteoporosis
- \_\_\_\_\_ scoliosis
- \_\_\_\_\_ broken bones
- \_\_\_\_\_ spinal problems
- \_\_\_\_\_ disk problems
- \_\_\_\_\_ lupus
- \_\_\_\_\_ TMJ, jaw pain
- \_\_\_\_\_ spasms, cramps
- \_\_\_\_\_ sprains, strains
- \_\_\_\_\_ tendonitis, bursitis
- \_\_\_\_\_ stiff or painful joints
- \_\_\_\_\_ weak or sore muscles
- \_\_\_\_\_ neck, shoulder, arm pain
- \_\_\_\_\_ low back, hip, leg pain
- \_\_\_\_\_ other

**Allergies**

- \_\_\_\_\_ scents, oils, lotions
- \_\_\_\_\_ detergents
- \_\_\_\_\_ other

**Respiratory & Cardiovascular**

- \_\_\_\_\_ heart disease
- \_\_\_\_\_ blood clots
- \_\_\_\_\_ stroke
- \_\_\_\_\_ lymphedema
- \_\_\_\_\_ high, low blood pressure
- \_\_\_\_\_ heart arrhythmia
- \_\_\_\_\_ poor circulation
- \_\_\_\_\_ swollen ankles
- \_\_\_\_\_ varicose veins
- \_\_\_\_\_ chest pain, shortness of breath
- \_\_\_\_\_ asthma
- \_\_\_\_\_ other

**Skin**

- \_\_\_\_\_ rashes
- \_\_\_\_\_ athletes foot, warts
- \_\_\_\_\_ other

**Cancer/Tumors (location)**

- \_\_\_\_\_ benign
- \_\_\_\_\_ malignant

Are there any other relevant factors in your health history that you would like us to be aware of? If yes, please explain\_\_\_\_\_

I attest that the statements and depictions contained on this form are true and correct to the best of my knowledge

SIGNATURE

DATE