PREMIER BODYWORK LLC

THERAPEUTIC MASSAGE AND MOVEMENT
715 HILL ST. SUITE 122 MADISON, WI 53705
www.pbmad.com 608-285-2124

## Massage Therapy and Bodywork Therapy
## Informed Consent for Minor Child
## (to be completed if client is under the age of 18)

I,_____(parent), hereby give permission to

Premier Bodywork LLC (WI License #12703-146) to provide _____ (my minor child/person under my guardianship) with therapeutic massage services as deemed appropriate to treat presenting conditions/injuries. I understand that therapeutic massage and movement education provided by my Premier Bodywork LLC 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 child's/charge's known physical conditions, medical conditions and medications, and I will keep the practitioner(s) I work with updated on any changes.

I understand that I am financially responsible for the minor, and that all statements contained in this consent apply equally to both me and the minor.

By signing this form, I confirm my consent for my child's/charge's practitioner(s) to treat them 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 child's/charge's practitioner(s). I further understand that I have the legal right to withdraw consent on behalf of my child/charge, either verbally or in writing, at any time, for any reason.

_____ _____

Parent Signature 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 premierbodyworkmadison@gmail.com and leaving a message.

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.

_____ _____

Client Signature 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.

**********

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 for further information.

**********

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_____

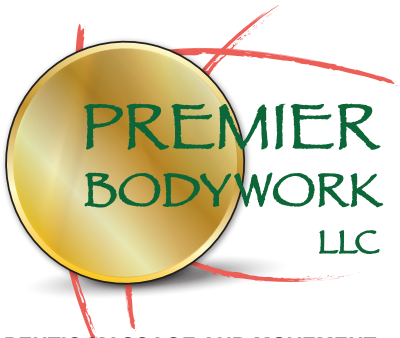
Phone_____Date of Birth_____

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