Gentle Touch Therapy LLC
Jennifer Rivas, OTR/L, CCST, MLD-C
Mobile Lymphatic Drainage Therapist – Las Vegas, NV
(702) 343 –2093
www. GentleTouchLV.com

Intake Form

Name:	Date of Birth:
Referring Doctor: Has your Doctor cleared you for MLD? YES or NO Do you have your Post – Op protocols? YES or NO	Address/ Email/ Phone Number:
Allergies (*Including latex, silicone, herbal supplements*):	Previous Surgeries (in the past year):

Do you currently have (or have a history) of any of the following medical issues or conditions affecting these bodily systems:

	YES	NO	In the Past?	Explain
Cancer				
Cardiac				
Lymphatic				
Diabetes				
Pregnancy				
Blood Clots				
Other				

Current Procedures

Surgical Procedure(s) and Date of Procedure (s):
Body Area:

Gentle Touch Therapy LLC
Jennifer Rivas, OTR/L, CCST, MLD-C
Mobile Lymphatic Drainage Therapist – Las Vegas, NV
(702) 343 –2093
www. GentleTouchLV.com

Garment(s):
Current Complaint:
Have you had previous MLD for this procedure? How many sessions?

Informed Consent

I hereby request and consent to Jennifer Rivas, OTR/L, CCST, MLD-C (hereby known as 'Clinician') of Gentle Touch Therapy LLC to perform treatment and care for _____ **(YOUR NAME)** as recommended by a physician and/or recommended by the Clinician.

1. I understand and am informed that, as in the practice of medicine, occupational therapy practices (hereby known as 'therapies') may have some risks and benefits to receiving treatment. I knowingly, voluntarily, and intelligently assume all risks involved using therapies recommended by the Clinician. I agree to release, indemnify, and defend the Clinician and her agents from and against any and all claims which I (or my representatives) may have any loss, damage, or injury arising out of the adverse reactions to which I have been given verbal notice or which may arise without the negligence of the clinician, or in connection with the use of such therapies, or arising out of or in connection referral to other practitioners for such therapies.
    a. I consent and acknowledge that Gentle Touch Therapy, LLC and its clinician are operating under the 'Health and Wellness" scope of occupational therapy practice as lymphatic and scar tissue massages are not medically necessary following plastic or any surgical procedure despite numerous benefits.
    b. I have independently and voluntarily sought out services and assume the risks and benefits of the modalities and therapies used by Gentle Touch Therapy LLC and its Clinician to promote health and wellness.
    c. I further acknowledge that it is my responsibility to inform the Primary Physician, and other healthcare providers, concerning my decision to use such therapies so they can determine, within their professional competence, whether any harmful or adverse effects are possible given their treatment of my medical conditions and/or post-operative status.

2. I understand that lymphatic drainage massage is provided for the basic purpose of lymphatic support. Also, I have been made aware that this therapy will require exposure of lymph nodes that are very close to sensitive areas of the body (inguinal nodes in the groin and axillary nodes under the arm close to the breast tissue). Careful draping through sheets and disposable garments will be used to maintain your highest level of modesty.
    a. I further understand that lymphatic drainage massage should NOT be construed as a substitute for medical examination, diagnosis, or treatment.
    b. If I experience any pain or discomfort during the session, I will immediately inform the Clinician so adjustments are made to my level of comfort.
    c. Because massage should **NOT** be performed 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 Clinician updated as to any changes during todays and all future sessions and understand there shall be no liability on the Clinician's part should I fail to do so.
    d. I understand that the Clinician reserves the right to refuse to perform lymphatic drainage massage on anyone whom she deems to have a condition for which lymphatic drainage massage is contraindicated.

i. **Examples of general contraindications for lymphatic drainage massage include the following (but not limited to):**
   1. Acute inflammation (infections) caused by bacteria, viruses, poisons. Tissues will red, hot, and painful with congestion accompanied by a fever. Lymphatic drainage will push these substances into the lymph channels before the body has a chance to eliminate them resulting in spreading of the toxic substances. It is best to wait until the body is clear of signs of infection prior to performing lymphatic drainage massages.
   2. Malignant Tumors/Active Cancers: Lymphatic drainage may spread cancer throughout the body.
   3. Thrombosis – Can lead to free floating blood clots into the circulatory system resulting in Deep Vein Thrombosis (DVT), pulmonary embolism (blood clot in the lungs), stroke, or heart attack.
   4. Major Heart Problems/ Heart Related or Low Protein Edemas: If the heart is not fully functioning or functioning appropriately, lymphatic massage may place additional stress on the muscle and cause significant harm to the heart. Additionally, if swelling is solely due to cardiac failure or if the patient is not taking appropriate medication to treat heart failure.
   5. Major Kidney Problems/ Renal Insufficiency Hemodialysis: Lymphatic drainage massage removes toxins and fluids from the body through the urinary system, if the kidneys and/or renal systems are not functioning properly lymphatic drainage massage may lead to renal failure.
   6. Presence of Necrotic Tissue/Skin Tissue Death

ii. **Examples of contraindications for lymphatic drainage massage of the Neck (but not limited to):**
   1. Any symptoms noted in general contraindications
   2. Cardiac Arrhythmia
   3. Hypersensitive Carotid Sinus – May affect blood pressure and heart rhythm
   4. Hyperthyroidism – Lymphatic drainage massage may release excessive amounts of thyroid hormones into the bloodstream.
   5. Active Neck Cancer

iii. **Examples of contraindications for lymphatic drainage of the Face (but not limited to)**:
   1. Any symptoms noted in general contraindications
   2. Any inflammatory processes as a result of acute infections to avoid spreading.
   3. Dental abscesses or infections

iv. **Examples of contraindications for lymphatic drainage of the Abdomen (but not limited to):**
   1. *Any symptoms noted in general contraindications*
   2. Pregnancy
   3. Abdominal Aortic Aneurysm
   4. Diverticulitis or Diverticulosis
   5. Severe Arteriosclerosis
   6. Inflammatory Bowel Diseases (I.e Crohn's Disease, Ulcerative Colitis)
   7. Irradiation of the abdominal region
   8. Pelvic Deep Vein Thrombosis
   9. Presence of clot-prevention devices (ie IVC filter)
   10. Unexplained pain

v. *Precautions for Lymphatic Drainage Massage (but not limited to):*
   1. These are other precautions (not contraindications) that should be taken into consideration prior to performing any lymphatic drainage therapies:
      a. Patients over 60 years of age should use caution during as lymphatic drainage massage could loosen and release built-up cholesterol plaques located in the arteries.

b. Menstruation
c. History of Treated Cancers
d. Vertigo, equilibrium, or tinnitus

3. **I agree to contact my Primary Physican, designated medical physician, or 911 immediately if I am experiencing any of the following symptoms:**
    a. Body temperature over 100.4 degrees F, with or without chills
    b. Fainting – not related to orthostatic hypotension
    c. Shortness of Breath
    d. Severe/Worsening of Fatigue
    e. Coughing up or Vomiting Blood
    f. Chest Pain (sharp/shooting or feels like severe pressure)
    g. Pus (ie yellow or green drainage) coming from the incision site
    h. Incision developing a 'bad' odor
    i. Incision is separating/opening or implant extrusion (implant is coming out of the body) is occurring.
    j. **Excessive** Amounts of Bleeding
    k. **Excessive** Amounts of Swelling
    l. Severe Confusion or Delirium
    m. Inability to urinate for 24 hours or have a bowel movement for more than several days
    n. Inability to walk or collapsing while walking
    o. Experiencing side effects to any medications
    p. Rapid heart rate (over 100 beats per minute)
    q. Severe Abdominal Pain
    r. Sudden and Drastic Color Change in Tissue (lighter or darker)
    s. Severe pain or increased pain anywhere in the body not relieved by medication
    t. Unexplained severe pain and/or swelling in the calf or leg, which may be a sign of a blood clot.
    u. A foot or both are turning blue, skin is cold to touch – may be indicative of blood clot.
    v. Loss of feeling or motion anywhere in the body

4. I understand that if I am unsure of symptoms being experienced, I will immediately contact my Primary Physician for further evaluation and medical guidance.

5. I understand that Occupational Therapists are not qualified to diagnose physical or mental illness, thus will be referred to the Primary Care Provider (hereby known as 'PCP') to address/discuss symptoms I may be presenting. I understand that Occupational Therapists are not qualified to prescribe under any circumstances and will be referred to my PCP for further discussion.
    a. I understand and acknowledge that any and all patient education during the session are *recommendation*s and should NOT be construed as a substitute for medical examination, diagnosis, or treatment.

6. I understand that as with any health treatment, there is no guarantee I will obtain satisfactory results with the use of these therapies. I understand that the use of these therapies does NOT preclude me from other treatments as well, however, I will inform any practitioners I am seeing about the various treatments I am using.

7. I understand that all service payments are due at the time of service and must be paid in full. Gentle Touch Therapy LLC is a cash pay private practice and does not accept insurance reimbursement. If requested, I have the right to be provided with a receipt of services rendered and payments made.
    a. In case of cancellations, I understand that the nonrefundable deposit will be forfeited.

b. I will provide Gentle Touch Therapy LLC a minimum of 24-hour notice for rescheduling appointments and the non-refundable deposit will be carried over to the new appointment time.
c. If you present or are observed to have contraindications for manual lymphatic drainage, you will be provided with a full refund.
    i. Payments and refunds are processed via 3rd party vendor (Square, Chase).
    ii. According to Square payment processor, please allow 2-7 business days for the payment to return to the original payment method.

8. I acknowledge, confirm, and allow Gentle Touch Therapy LLC to send the appointment reminders via email, text, or phone call 24-48 hours prior to the set appointment time for confirmation.
    a. In the event of "No Call/ No Show" - Clinician arrives to the home and I am unavailable or not home, I understand that I will lose my nonrefundable deposit and any/all relationships will be terminated by the Clinician and Gentle Touch Therapy LLC.
    b. Due to the nature of 'mobile' services, I understand, acknowledge, and allow a 15 minute grace period from the appointment time to be permitted to account delays as a result of traffic/accidents.
    c. In the event that the Clinician is running late (more than 15 minutes) as a result of uncontrollable variables, I will be notified of estimated time of arrival as soon as possible and be offered the option to reschedule appointment time to a later date/time.

9. To ensure the safest level of care and working environments, Gentle Touch Therapy LLC and its Clinician ask that any/all pets be placed in a secure and closed area of the home prior to the Clinician entering the home.
    a. In the event of an animal attack or destruction of property, I understand that I will be held financially responsible for all costs of reimbursement.

10. I consent and authorize Gentle Touch Therapy LLC to administer occupational therapy treatments under the direction and supervision of a registered occupational therapist. Gentle Touch Therapy LLC reserves the right to terminate patient relationships at any time and at the Clinician's discretion.
    a. I understand that the Clinician upholds all levels of professionalism to ensure the patient's dignity is preserved. Furthermore, I understand that any illicit or sexually suggestive advances or remarks made by me will result in immediate termination of the session and relationship.

11. I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss it with a member of Gentle Touch Therapy LLC if I chose.

I agree to hold Gentle Touch Therapy LLC and its Clinicians harmless for claims or damages in connection with treatment. This is a contract between myself and Gentle Touch Therapy LLC, and I understand that it is also a release of potential liability.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____ _____

Client Signature & PRINTED Name **Date**

Gentle Touch Therapy LLC
Jennifer Rivas, OTR/L, CCST, MLD-C
Mobile Lymphatic Drainage Therapist – Las Vegas, NV
(702) 343 –2093
www. GentleTouchLV.com

Photo Release Form

For good and valuable consideration, the receipt of which is hereby acknowledged, I, _____ **(YOUR NAME),** hereby grant Gentle Touch Therapy LLC permission to use my likeness in a photograph in any and all of its publications, including but not limited to all of Gentle Touch Therapy LLC's printed and digital publications. I understand and agree that any photograph using my likeness will become property of Gentle Touch Therapy LLC and will not be returned. Gentle Touch Therapy will maintain my identity confidential and will not distribute or release identifiable personal health information.

I acknowledge that since my participation with Gentle Touch Therapy LLC is voluntary, I will receive no financial compensation.

I hereby irrevocably authorize Gentle Touch Therapy LLC to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing Gentle Touch Therapy LLC programs or for other related, lawful purposes. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Gentle Touch Therapy LLC from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

_____ _____

Client Signature & PRINTED Name **DATE**

Gentle Touch Therapy LLC
Jennifer Rivas, OTR/L, CCST, MLD-C
Mobile Lymphatic Drainage Therapist – Las Vegas, NV
(702) 343 –2093
www. GentleTouchLV.com

Red Light Therapy Consent Form

RED LIGHT THERAPY (AKA LLLT – Low Level Light Therapy or PBMT – Photobiomodulation Therapy)

- Always wear protective eyewear. Failure to wear protective eyewear may result in burns or long-term injury to the eyes.
- You should prepare your skin for your session prior to your arrival. For optimal results, skin should be free of deodorant, makeup, fragrances, oils, and lotions. Remove jewelry.
- Certain Medications or cosmetics may increase your sensitivity to the Red Light Therapy.
- For optimal results recommended red light therapy schedules are 1-3 days per week, for 4-12 weeks.
- After treatments sit up slowly to prevent dizziness.
- I am over 18 years of age.
- I understand that Red Light Therapy should not be administered to people with the following conditions, and I do not have any of these conditions.
  a.Persons diagnosed with basil cell carcinoma
  b.Pregnancy
  c.Epilepsy
  d.Thyroid Condition
  e.Taking medications that cause sensitivity to light (example: tetracycline)
  f.Broken or inflamed areas of the skin.

I understand that Red Light Therapy is not intended to take place of medical care or medications. To my knowledge, I have no medical condition which would prohibit me from using Red Light Therapy. I acknowledge that the results of Red Light Therapy do vary, and that no guarantees of specific results are offered or implied. I have been given adequate instructions for the proper use of the equipment, understand the risks involved, and use it at my own risk. I hereby agree to release the owners, operators, and manufacturers from any damages that I might incur due to the use of this facility.

Pre/Post Treatment Instructions:

It is important that the treated area (whole body) be clean, remove all moisturizers and creams, prior to starting any treatment session. In order to maximize your treatment, you must drink at least 8 oz. of water before and after all treatment sessions, practice healthy eating habits, alcohol consumption, and smoking while undergoing your series of light therapy sessions.
Most clients will continue to see improvements over weeks post initial sessions. As with any Red Light Therapy, individual results will vary from person to person and no guarantees can be made that expected or anticipated results will be achieved. I am aware that follow-up treatment(s) may be necessary for desired results. Most patients require a number of treatment sessions over several weeks with gradual results occurring over time.

Risks and Side Effects:

Red Light Therapy treatments are non-invasive and are intended not to produce any thermal damage or pain. Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. It is important to notify the treatment facility if you have any problems or concerns such as uncomfortable heat from the pad or panel, prolonged redness of the skin, swelling, itching or severe headaches during or after the treatment. These are all indications of sensitivity to light. These side effects rarely occur and usually subside within 24 hours of discontinuing the treatment. **I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Alternative treatment choices are available. With this in mind, I am choosing this non-invasive treatment option.**

If you have/had or use any of the following then you are not a candidate for red light therapy treatments.

Photophobia, Porphyria, Lupus Erythematosus, Exogenous Eczema, Eye Disease/Retinal Abnormalities, Epilepsy and Seizures, Hypomelanism (albinism), Heart Trouble/Pacemaker, Pregnant, Infectious or Contagious conditions.

Gentle Touch Therapy LLC
Jennifer Rivas, OTR/L, CCST, MLD-C
Mobile Lymphatic Drainage Therapist – Las Vegas, NV
(702) 343 –2093
www. GentleTouchLV.com

*Please carefully look over the following list of medications and check off any you have taken in the past 7 days. These medications have been known to cause light sensitivity.

- Anti-Arrhythmic Amiodarone (Pacerone® Cordarone® Aratac®)
- Chlorpromazine (Thorazine®, Chloramead®, Chlordryprom®, Chlor® Promanyl®, Largactil®, Promapar®, Promosol®, Terpium®, Sonazine®)
- Acne Oral Isotretinoin (Accutane®, Accure®, Aknenormin®, Amnesteem®, Ciscutan®, Claravis®, Isohexal®, Isotroin®, Oratane®, Sotret®, Roaccutane®)
- Topical Isotretinoin (Isotrex®, Isotrexin®)
- Anti-Psychotic Haloperidol (Haldol®)
- Trifluoperazine (Stelazine®, Clnazine®, Novoflurazine®, Pentazine®, Solazine®, Terfluzine®, Triflurin®, Tripazine®)
- Anti-Fungal Griseofulvin (Grifulvin®)
- Antibiotics Tetracycline (Helidac®, Terra-Cortril®, Terramycin®, Sumycin®, Actisite®, Bristacycline®, Actisite®, Tetrex®, Doxycycline®, Ciprofloxacin®)
- Norfloxacin (Noroxin®, Quinabic®, Janacin®)
- Ofloxacin (floxin®, Oxaldin®, Tarivid®)
- Nalidixic acid (NegGam®, Wintomylon®)
- Ciprofloxacin (Cipro®, Ciproxin®, Ciprobay®)
- Minocycline (Minomycin®, Minocin®, Arestin®, Akamin®, Aknemin®, Solodyn®, Dynacin®, Sebomin®)
- Oxytetracycline
- Demeclocycline
- Lymecycline
- Cancer Methotrexate (MTX®, Aminopterin®, Ledertrexate®)
- Arthritis Auranofin (Ridaura®)

The above drugs are currently the most common medications associated with photosensitivity and are by no means a complete list of all photosensitive medications. Herbs and over the counter medications such as psoralen and St. John's Wort can also cause sensitivity to light, so it is important to disclose any and all medications or herbs you are currently taking.

I agree

I agree to adhere to any and all safety precautions and regulations during the treatment. I have read and understand the Pre and Post Treatment Instructions. I understand that compliance with recommended pre and post procedure guidelines are critical in determining the effectiveness of the treatment sessions. The nature and purpose of the sessions has been explained to me. I have carefully read and understand this agreement and fully understand its contents. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. **I understand the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks.**

I authorize Gentle Touch Therapy LLC and its clinician to perform Red Light Therapy treatments on me. I release Gentle Touch Therapy LLC and its clinician from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age and sign this at my own free will.

Signature: _____

Printed Name:_____

Date: _____