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:

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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 prescribed 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 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 condition.

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 towels 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.

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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.

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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. Written Informed Consent of Clinical Documentation
    a. I understand and have been made aware that as an occupational therapist and clinical medical professional, the clinician at Gentle Touch Therapy LLC completes electronic documentation of all initial evaluations, progress notes, and discharge recommendations using HIPAA compliant documenting systems.

12. Gentle Touch Therapy LLC will not release medical records without obtaining written consent from the patient.

13. 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.

_____ _____

Patient Signature Date

_____

Printed Patient Name

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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.

_____ _____

Patient Signature DATE

_____

Patient Printed Name

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