To My Newest Client:

Welcome to our clinic! The following is an explanation of our policies. We believe that a clear understanding will allow us both to concentrate on the most important issue: Regaining and maintaining your health. We are happy to answer any questions that you may have and are grateful to be at your service.

- The procedure time for your treatment is 45 – 60 minutes. When you are scheduled, one full hour is set aside specifically to meet your needs. We do not double book appointments and are not able to place another client in your space without prior notice. Therefore when you are scheduled, it is imperative that you make your appointment and arrive on time.

- Cancellation notice is required 48 hours prior to your appointment time. If for any reason you are unable to keep your appointment. This will permit us to give that time slot to another client in need of treatment. If this notice is not given, there will be a $80.00 *charge".* This fee must be paid as soon as you are notified of your missed appointment.

- Massage Therapy fee is $32.50-$40 per unit (4 Units = an Hour). If the massage session is paid for in full, on the day of your massage, then a "time of Service Discount" will apply. Under no other circumstances will this fee be adjusted. Understand and agree that policies are an arrangement between carrier and client. Insurance will be verified and billed as a courtesy to you, however client understands that he/she is responsible for treatment not covered by the insurance. In the event that insurance does not pay, then client becomes responsible for full payment of services. A 1% interest per month will be charged on balance remaining after 60 days. If by chance, you do not pay your bill and you are sent to collections, you will be responsible for any and all fees charged by the collection agency.

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation and energy flow. I agree to communicate with my practitioner any time I feel my well-being is being compromised.

My signature states that I have read and agree to this policy.

Signature:_____ Date: _____

Patient Information
Confidential

Name: _____ **Occupation:** _____
(First, Last, Middle Initial)

Address: _____ **Employer:** _____

City-State-Zip: _____ **Emergency Contact:** _____

Home Phone#: _____ **Emergency Phone#:** _____

Work Phone#: _____ **Birthdate:** _____

Physician: _____ **Social Security #:** _____

PLEASE READ THROUGH AND CHECK THE FOLLOWING THAT APPLY TO YOU:

☐ Diabetes	☐ Cancer of any kind	☐ Spinal Problems
☐ High/Low Blood Pressure	☐ Hepatitis	☐ Epilepsy
☐ HIV	☐ Heart Condition	☐ Venereal Disease
☐ Lymphedema	☐ Asthma	☐ Breathing Difficulty
☐ Tuberculosis	☐ Sinus Problems	☐ Athletes Foot
☐ Warts	☐ Constipation	☐ Gas/Bloating
☐ Diverticulitis	☐ Irritable Bowel Syndrome	☐ Muscular Dystrophy
☐ Herpes/Shingles	☐ Numbness/Tingling	☐ Chronic Pain
☐ Fatigue	☐ PMS	☐ Eating Disorder
☐ Depression	☐ Drug/Alcohol Addiction	☐ Nicotine/Caffeine
☐ Low Bck/Hip/Leg Pain	☐ Jaw Pain	☐ Spasms/Cramps
☐ Headache/Head Injury	☐ Neck/Shldr/Arm Pain	☐ Lupus
☐ Sprains/Strains	☐ Broken/Fractured Bones	☐ Bursitis
☐ Tendonitis	☐ Bone/Joint Disease	☐ Concussion
☐ Nervousness/Dizziness	☐ Convulsions	☐ Multiple Sclerosis

- ✓ Explain anything checked above: _____

_____

☐ Arthritis: If yes, Osteo or Rheumatoid (please circle) and where is it located? _____

☐ Varicose Veins/Blood Clots or any other Circulatory problem? _____

☐ Allergies/Skin Problems (please list): _____

- ➢ Are you currently seeing a psychotherapist and/or attending regular support group meetings? Yes☐ No☐
- ➢ Are you seeing a Physician at this time, other than regular check-ups? Yes☐ No☐
- ➢ List All Medication that you are currently taking, including vitamins: _____

_____

- ➢ Have you had any accidents or surgeries in the past 6 months to a year?.....Yes☐ No☐

If yes, please list: _____

- **Do you feel like you are coming down with a cold or the flu (or have an infectious/contagious disease)? Yes☐ No☐…If yes, please explain:** _____
- **Are you experiencing sleep disorders at this time? .....Yes☐No☐**
- **Are you Pregnant?.....Yes☐No☐ If so, what stage?** _____
- **Do you wear: ..... ☐Contact Lenses..... ☐Dentures..... ☐Hearing Aids**
- **Do you exercise regularly or participate in sports? If yes, please explain?..... Yes☐ No☐**

_____

- **Do you have any needs that require special attention? If yes, please explain: ..... Yes☐ No☐**

_____

- **Do you have any other medical condition that I should be aware of before you receive massage? If yes, please explain:** _____
- **Have you ever had a professional massage? ..... Yes☐ No☐**
- **What results would you like from this massage?** _____

I certify that the above information is correct the best of my knowledge. I will not hold my massage Therapist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

I have disclosed all medical conditions that I am aware of and will inform my massage Therapist of any change in my health status.

I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me.

I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

Signature:_____ **Date:** _____