Massage Wellness Chart

Be Well Massage Therapy, LLC

Name: _____ Phone Number: _____ Cell Phone Carrier for Appointment Reminders: _____

Address: _____ City _____ State _____ Zip _____

Email _____ DOB _____ Occupation _____

How did you hear about us? Doctor Web: Sign: Other_____

Please answer the following questions to ensure a safe and comfortable massage experience by providing the following information. Check all that applies and provide any necessary clarification.

- ☐ Allergies (nuts, shellfish, scents, etc.): _____
- ☐ Arthritis: _____
- ☐ Blood Clots: _____
- ☐ Blood pressure conditions: _____
- ☐ Chronic pain (joint, muscle, nerve): _____
- ☐ Diabetes: _____
- ☐ Fibromyalgia: _____
- ☐ Headaches: _____
- ☐ Heat Sensitivity: _____
- ☐ Heart Problems: _____
- ☐ History of strokes: _____
- ☐ Infections (Flu, Mersa, HIV, Shingles, Warts) _____
- ☐ Injuries: _____
- ☐ Immune system deficiencies: _____
- ☐ Medications: _____
- ☐ Pain, numbness, tingling: _____
- ☐ Skin conditions (bruising, acne, rash): _____
- ☐ Surgeries (please add dates): _____
- ☐ Varicose Veins: _____
- ☐ Other: _____
- ☐ Pregnancy (how far along are you?): _____

Daily activities affected by stress/pain/current condition: _____

_____

Desired Massage Pressure: LIGHT MEDIUM DEEP

Are you comfortable with having a therapeutic massage on the following areas?

Abdomen: _____ Pectoral Muscles: _____ Scalp: _____ Face: _____

Feet: _____ Gluteal Muscles _____

It is your responsibility to inform the therapist of any pre-existing conditions, limitations or specific sensitivites and to inform your therapist if you feel any discomfort during the session. If you do experience discomfort, please ask the therapist to adjust the level of pressure. You understand and voluntarily accept any risks which you have been adivised about associated with your massage, or from any use of the company's facilities, and hereby release Be Well Massage Therappy, LLC (including its employees, practitioners, agents and insurers) from liability for any injury, including, without limitations, personal, bodily, or mental injury, economic loss or any damage to you resulting therefrom. You further hereby release all of the foregoing personnel and entities from all liablity arising drom any such injury or damage resulting from your failure to disclose any pre-existing conditions, limitations or specific sensitivities, or your failure to inform your therapist of any discomfort during the session. Your therapist does not diagnose illness, disease, or other physicial or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. If during your session you feel uncomfortable, simply ask your therapist to end the session. The undersigned acknowledges that he/she has read this agreement.

Signature: _____ Date: _____

Clinic Policies  Be Well Massage Therapy

Please initial the following:

_____ **Cancellation Policy**: A cancelled appointment delays our work. When you must cancel, please give us at least 24 hours notice. We are rarely able to fill a cancelled session unless we know at least 24 hours in advance. In you are unable to provide at least 24 hours notice when you cancel, you will be charged the full fee for your session unless we are able to fill it with another client. (You should note that insurance companies do not reimburse for missed appointments.) The only time we will waive this fee is in the event of serious or contagious illness or emergency. Thank you in advance for understanding.

_____ Late arrivals to massage appointments will result in a shortened massage session. Efforts will be made to provide full massage time, if the therapists's schedule permits.

Therapeutic massage prices when paid at the time of service are as follows:

Wellness Members:	Non-Members
$119 per 90 minutes	$135 per 90 minutes
$79 per 60 minutes	$95 per 60 minutes
$40 per 30 minutes	$55 per 30 minutes

_____ I understand that all Co-Pays, Patient Responsibilities, and deductible fees are due at the time of service.

_____ **A QUOTE OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. BENEFITS ARE SUBJECT TO ALL CONTRACT LIMITS AND THE MEMBERS STATUS ON THE DATE OF SERVICE. ACCUMULATED AMOUNTS SUCH AS DEDUCTIBLE MAY CHANGE AS ADDITIONAL CLAIMS ARE PROCESSED**

_____ I understand that I am financially responsible for any charges not covered by my insurance.

Signature: _____ Date: _____