

## 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 50 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 24 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 **“\$50.00 charge”**. This fee must be paid as soon as you are notified of your missed appointment.
- **Massage Therapy fee is \$30.00-\$40.00 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:

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

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

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➤ 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: \_\_\_\_\_