

Client Registration & Health information

Name _____ Date: _____

Address _____ City _____ State _____ Zip _____

Phone: _____ Cell _____ DOB _____

Occupation: _____

Emergency contact _____ Phone _____

*How did you hear about us? _____ Referred by _____

E-mail (optional) _____

Have you had Massage or Bodywork before? Yes No

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain |
| <input type="checkbox"/> Surgeries/Accidents | <input type="checkbox"/> HIV positive | <input type="checkbox"/> infectious disease | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> High-Low Blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Low Back pain |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Rashes | <input type="checkbox"/> Headache/migraine |
| <input type="checkbox"/> Stroke/ blood clots | <input type="checkbox"/> Herniated disk | <input type="checkbox"/> Warts | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Breathing difficulties | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Numbness/tingling |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Athletes foot |

Other/Explain: _____

Current medications _____

I understand that massage and bodywork sessions are for the purpose of relaxation, stress reduction and relief from pain or muscle spasms. I further understand bruising or flue like symptoms may occur as result of massage. I have provided all my known medical information. I acknowledge that manual therapy is not a substitute for medical diagnosis and treatment and is recommended that I contact a licensed health care provider for any medical conditions or concerns that I might have.

24 Hour Cancellation Policy

By signing you acknowledge that scheduled services are the core of our business. Because appointments are reserved especially for you we ask that you notify us 24 hours in advance to change or cancel your appointment without penalty.

Signature _____ Date _____

Signature Date Parent/guardian (if under 18) Date

CONSENT TO THE USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION FOR THE TREATMENT. PAYMENT OR HEALTH CARE OPERATIONS OF ORGANIC WELLNESS

I understand that as part of my health care, Organic Wellness originates and maintains paper and electronic records describing my health history, symptoms, examinations and test results, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying treatment to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality.

I understand and have been provided with Notice of Privacy Practices (Revision Dated April 14, 2003) that provides a more complete description of how medical information about me may be used and disclosed. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for specific purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

I wish to have the following restrictions to the use of disclosure of my health information:

I understand that I may revoke this agreement in writing, except to the extent that the organization has already taken actions thereon. I also understand that by refusing to sign this consent, this organization may refuse to treat me as permitted by section 164.506 of the Code of Federal Regulations.

I understand that as part of this organizations treatment, payment or health care operations, it may become necessary to disclose my PHI to another entity, and I consent to such disclosure for these permitted uses, including disclosure electronically via fax or computer
I fully understand and accept the terms of this consent

Client Signature

Date

Reason for Refusal to sign: _____

Massage Therapists Signature

Date