Skilled Touch
Health & Healing

Client Information Form

Name:______________________________ Birth date:__________________________
Address:____________________________
____________________________________ Occupation:________________________

Phone: (   )_______________________ How did you hear about us?
E-mail:______________________________ ___ Referral-
____

- Please send newsletters/coupons ___Website ___ Driving by
- Please send appt reminders via text
  Other_________________________________

What is the main reason for your visit? Any specific concerns?__________________________
____
____
____
____

List any serious injuries, broken bones, or major operations/surgeries you have had:
____
____
____
____

Please circle any items that pertain to you: Contacts Pacemaker Hearing Aid Pregnant

Have you ever had a therapeutic massage before? ____ Yes ____ No
Mark any personal history of the following:

___ Headaches	___ Chronic Fatigue	___Blood Pressure High/low
___ Allergies	___ Diabetes	___ Osteoporosis
___ Anxiety	___ Digestive Disorders	___ Arthritis __
___Fibromyalgia	___Seizures	___Blood Clots
___ Skin Disorders/Scars	___Chronic Pain	___Cancer

I understand that therapeutic massage or Lymphatic Enhancement Therapy is not intended to be the primary treatment for any specific illness or disease process, and is not a substitute for appropriate medical care. Instead, it works with the body to enhance its own natural healing and recuperative powers. I understand that if I experience any pain or discomfort during the session, I should inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. A copy of the HIPPA policy is available to me upon my request.

Please Initial:

_____It is also understood that any illicit or sexually suggestive remarks or advances made will result in immediate termination of the massage session.
_____CANCELLATION POLICY: We hold your appointment specifically for YOU. Should you not be

able to keep your appointment, please respect our time as well by providing a 24 hour notice of appointment cancellation. If less than 24 hours, you will be charged 50% of the appointment services.

____

Signature Date

Policy Disclosure and Information Consent Form

This policy disclosure and information consent form is an honest effort on the part of this facility to comply with the Privacy Rule on the HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA).

The Privacy Rule establishes a federal requirement that most doctors, hospitals, or other health care providers obtain a client's written consent before using or disclosing any of their personal health information. It generally requires this office to take reasonable steps to limit the use, disclosure of, and/or requests for protected health information (PHI) to the minimum necessary to accomplish the intended purpose.

The following provisions specify the polices and procedures implemented at the establishment in accomplishing that end:

- That any personal health information (PHI) provided by you for the purpose of treatment, health care operations, coordination of care, or payment:

  a. will be protected in its entirety in all forms (oral/written/electronic)

  b. will not be shared or released to <u>any</u> individual, agency, or lawful authority without your prior written consent (or that of your personal representative/guardian/power of attorney).

  c. will be available for you to examine, request corrections of or make amendments to, request any disclosures pertaining to, or obtain a copy of at any time.

- That your written consent need only be obtained this one time for all subsequent care provided at this facility.
- That you can provide a written request to <u>revoke</u> consent at any time during care, which would not apply to care or records prior to such a request
- That you have a right to file a formal complaint with this facility's privacy compliance officer (PCO) about any possible violations of these policies and procedures.

Signature Date