VITA MASSAGE

Confidential Client Health Information

Name: _____ Date: _____ Birthdate: _____

Address: _____ Referred By: _____

_____ Occupation: _____

Home #: _____ Work #: _____ Physician: _____

Cell #: _____ E-mail: _____

MASSAGE HISTORY/TREATMENT INFORMATION

	Yes	No	
Previous professional Massage	☐	☐	Frequency of Massage: _____
			Date of Last Massage: _____

Which body areas need the most attention? _____

Please check the areas/muscles groups that you give permission to receive massage:

Yes	No		Yes	No	
☐	☐	Scalp	☐	☐	Abdomen
☐	☐	Neck	☐	☐	Pectoral Muscles (front of shoulder
☐	☐	Face	☐	☐	Gluteal Muscles (Buttocks)
☐	☐	Back	☐	☐	Legs
☐	☐	Arms/Hands	☐	☐	Feet

Any areas to be careful of? (Recent chronic injuries, skin conditions, etc.) _____

_____

Are you currently under a doctor's care? Yes ☐ ☐ No If yes, Please explain _____

_____

List Stress reduction/exercise activities: _____

Physical strains form occupational/hobby activities

_____

_____

_____

List Current medications, including over the counter:

_____

_____

_____

Medical History: (Include year and treatment received)

Surgeries:

_____

_____

_____

Accidents:

_____

_____

_____

Chronic Conditions: _____

_____

Check any of the following that you are wearing now:

- ☐ Contact Lenses
- ☐ Pace Maker
- ☐ Hearing Aid
- ☐ Hairpiece

Are you currently pregnant? YES ☐ ☐ NO If Yes List Trimester You Are In _____

How did you hear of our practice? _____

Health History **Please list any areas of concern**

Yes No

MUSCULO-SKELETAL

- ☐ ☐ Tendentious
- ☐ ☐ Arthritis
- ☐ ☐ Sprains/Strains
- ☐ ☐ Low Back/Hip Pain
- ☐ ☐ Neck/Shoulder Pain
- ☐ ☐ Headaches/Head Injury
- ☐ ☐ Spasms/Cramps
- ☐ ☐ Jaw Pain/TMJ
- ☐ ☐ Other _____

CIRCULATORY & RESPIRATORY

- ☐ ☐ Heart Condition
- ☐ ☐ Varicose Veins
- ☐ ☐ Blood Clots
- ☐ ☐ High or Low Blood Pressure
- ☐ ☐ Sinus Problems
- ☐ ☐ Lymphedema
- ☐ ☐ INFECTION DISEASE
- ☐ ☐ Disease Names _____

SKIN

- ☐ ☐ Allergies
- ☐ ☐ Rashes
- ☐ ☐ Athlete's foot
- ☐ ☐ Dry Skin
- ☐ ☐ Oily Skin

DIGESTIVE _____

NERVOUS SYSTEM

- ☐ ☐ Herpes/Shingles
- ☐ ☐ Numbness/Tingling
- ☐ ☐ Chronic Pain
- ☐ ☐ Fatigue
- ☐ ☐ Sleep Disorders
- ☐ ☐ Other _____

REPRODUCTIVE

- ☐ ☐ Pregnant? Stage _____

OTHER

		Cancer/Tumors
		Diabetes
		Depression
		Drug/Alcohol/addiction
		Nicotine/Caffeine addition
		Domestic Abuse
		Sexual Abuse

Consent to Treat:

It is my choice to receive massage therapy. I understand that possible benefits of the session will include stress reduction; relief from muscular tension, spasm or pain; and increased circulation and energy flow. I agree to communicate with my therapist at any time if I feel like my well-being is being compromised.

I understand that massage therapists do not diagnose physical or mental diseases, prescribe medical treatments or pharmaceuticals, nor perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis.

I have stated all medical conditions that I am aware of and will update the massage therapist of any changes in my health.

SIGNATURE: _____ DATE: _____

Practice Policies:

We are excited to partner with you on your journey to health and wellness. Massage therapy is a personal service that requires skill, focus and energy. Our therapists schedule their time according to your request and plan you session well before your arrival. Multiple conversations take place among our staff in preparation for you to receive the highest level of coordinated care.

Appointment Reservation: In order to reserve your time with our therapist, a credit card must be on file at the time your appointment is confirmed.

Payment: Payment is due at the time service is rendered and can be made in the form of cash, check or credit card. If you choose to pay by cash or check, the credit card information you used to reserve your appointment is destroyed appropriately.

Insurance: When utilizing auto or workman's compensation insurance, we are happy to submit claims to your insurance company on your behalf. Payment, from you, is due at the time services are rendered and your insurance company will reimburse your expense based on our billing and available claims funds. We cannot manage your expense based on other medical professionals bills submitted to your insurance company and therefore we cannot guarentee all massage service rendered will be covered by your insurance company. Our staff works diligently with you and your insurance company to check available claims funds to utilize. Please inquire regarding massage pricing when utilizing workmen's compensation and auto insuarnce.

HSA and Flex Spending Account Payments: We are able to accept debit or credit card payments from your HSA or flex spending account. If you were not issued a credit card but do have availibility of these funds, we can provide a receipt for you to submit for reimbursement.

Appointment Cancellation: We require 24 hours-notice to cancel your appointment. Our team of therapists are dedicated to your care and set aside their time to focus on you. Once your appoitnment is confirmed, it is your time with our therapist. If find that you need to cancel your appointment inside of 24 hours and can send someone in your place, family, friend, co-worker, or if we are able to refill your time there will be no charge. If the required notice is not received, the credit card you reserved your appointment with will be charged for your full appointment time.

_____

Client Name (Please Print

_____ _____

Signature Date

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Your health information privacy:
As part of providing professional care, I am committed to maintaining the privacy of your personal health information. I am also required by law to keep your information private. HIPPA (The Health Insurance Portability and Accountability Act) requires that I provide you with this notice of privacy practices. I will use information about your health mainly to provide you with treatment,to arrange payment for our services, to file claims with insurance companies, and for some other business activities that are legally referred to as “health care operations.” If it will be useful to disclose or release your information for any other purposes, I will ask you to sign an authorization form for release of informaiton. Your health information is confidential. However, there are instances when the law requires me

For Example:

- If there is a serious threat to your health and safety or the health and safety of another individual or the public. I only share information with the person or organization that is able to help to prevent or reduce the threat.
- If there is any suspicion of child abuse, neglect, molestation, or sexual abuse.
- If there is any suspicion of elder abuse or neglect.
- If you are unable to take care of basic needs for yourself.
- If disclosure of your health information is court ordered.

Your rights regarding your health information:
- You can ask me to communicate with you about your health and related issues in a way that is more private for you. For example, you can ask me to call you at work and not at home, or ask me not to leave a telephone message on a home answering machine.
- You have the right to ask me to limit what I tell people who are either involved in your care or the payment for your care, such as family members and friends. I will keep our agreement except if it is against the law, in an emergency, or when the information is necessary to treat you.
- You have the right to look at the health information I have about you, such as your treatment and billing records. Please contact me to arrange how to see your records.
- If you believe certain information in your record is incorrect or missing, you can ask me to make some kinds of changes to your health information. You must make this request in writing and tell me the reasons you want to make the changes.
- You have a right to copy of this notice. If I change this notice, I will post the new version on my website or you can obtain a new copy from me.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can contact the United States Secretary of Health and Human Services at:
The Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Room 515F, HHH Bldg.
Washington D.C., 20201.
- Filing a complaint will not change the health care I provide you in any way.

If you have any questions regarding this notice or your health information privacy, please discuss them with me.

_____
Client Name (Please Print

_____ _____
Signature Date