# Massage Client Information Form

First Name_____ Last Name_____ DOB_____

Address: _____ City/State/Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

General Health Condition_____ Blood Pressure: Low Norm High

SS#: _____ Are you pregnant? Yes No

Have you had any serious or chronic illness, operations, chronic virus infections, traumatic accidents or medical conditions?

_____

Are you under a doctor's or other health practitioner's care?_____

If so, for what condition(s)?_____

Are you on any medication? Yes No If so, what?_____

Do I have permission to contact your doctor/therapist? Yes No

Names of Doctors, chiropractors or other health practitioner(s):

Name_____ Name _____

Address_____ Address_____

Telephone_____ Telephone_____

Why did you come for our services? (Relaxation, pain, therapy, etc.)_____

What results would you like to achieve with our work?_____

Have you had any massage therapy before? Yes No If so, what when was your last massage?_____ How did you find out about our services?_____

Were you referred to this office? _____ By whom?(so we may thank them)_____

In case of emergency notify: Name_____ Phone_____

Please check off the areas of the body you give permission to receive massage:

Abdomen ____ Buttocks ____ Feet ____ Neck ____ Arms ____

Chest ____ Head ____ Back ____ Face ____ Legs ____

# Informed Consent to massage therapy treatment

I hereby request and consent to massage therapy treatment and any other therapies that fall under the scope and practice of the professional treating me.

I understand that I will be receiving massage therapy for therapeutic reasons. I understand and am informed that there are some risks to treatment including, but not limited to, soreness, bruises and inflammatory pain. I do not expect the therapist to anticipate or explain all risks and complications and rely on the therapist to exercise all reasonable skill during the course of treatment.

I understand that massage therapy may involve some undressing. I understand that at all times the therapist will abide by my wishes with regards to my comfort levels of undress. I understand that I can request that an area is not to be treated and/or exposed. Draping will be used at all times to maintain my modesty.

I understand breast massage will not be engaged in during any session.

I understand that if I am uncomfortable for any reason, I may ask the massage therapist to cease the massage and my request will be honored.

I have read, or have had read to me, the above consent. I have completed the information on the previous page to the best of my knowledge. I understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care when it is indicated.

I understand that information exchanged during any massage session is educational in nature and is intended to help me become more familiar and conscious of my own health status and is to be used at my own discretion. I have also had the opportunity to ask questions regarding its content, and by signing below, I agree to the above named procedures. I intend this consent to cover treatment for my present condition as well as future conditions for which I seek treatment.

**Any behavior or remarks of a sexual nature will not be tolerated. Clients who ignore this request will be responsible for payment in full and asked to leave immediately!!**

PLEASE GIVE 24 HOUR NOTICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT.

FAILURE TO GIVE 24 HOUR CANCELLATION NOTICE MAY RESUL IN A MISSED APPOINTMENT CHARGE OF $25.00.

I ACCEPT THAT I WILL BE RESPONSIBLE FOR THIS FEE IN I FAIL TO CANCEL MY APPOINTMENT.

Patient signature_____ Date_____

Therapist Signature_____

## Assignment of Insurance Benefits

I authorize and direct that payment be made directly to **Water Street Family Chiropractic** for any and all insurance benefits or reimbursement for services rendered by him or her which amounts would otherwise be payable to me under any insurance or prepaid healthcare plan.

## Patient Agreement

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare the necessary reports and forms to assist me in making collection from the insurance company and that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also authorize exams, x-rays, and/or other procedures deemed necessary by this office. Should I become a patient, I understand that I am liable for any financial arrangements that will be made.

## Release of Information

I authorize the release of any information concerning my health and health care services to my insurance companies or prepaid health plan of Medicare.

## Notice of Privacy Practice

I am acknowledging that I have received the Notice of Privacy Practices from Water Street Family Chiropractic.

## Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Jon Sibert and/or other licensed doctors of chiropractic who in the future work at Water Street Family Chiropractic. I understand that I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all these risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I understand that results are not guaranteed.
I have read, or have read to me, the above consent, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

**Date** **Patient Signature**