



Bodywork Therapy Inc.

Advanced

"Our mission is a commitment to empower by education, with wisdom, skills and courage to reach all depths of healing of the mind, body and soul" Kylan Skinner

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

PHONE: home _____ work _____ cell _____

OK to make cell phone text reminders? _____ What's your cellphone service? _____

Email Address: _____

Date Of Birth: _____ / _____ / _____ Occupation: _____

Emergency Contact: _____ Phone _____ Relationship _____

Referred By: _____

Please List any hospitalizations, accidents, surgeries and/or serious injuries that apply to you
(please include dates) _____

Do you have any chronic conditions or illnesses? If so, what kind(s)? _____

Are you currently being treated by physician or health care provider? Yes _____ No _____

If yes, please explain: _____

Are you currently taking any medications (includes supplements and over the counter medication)?

Yes_____ No_____ Please Explain:_____

Do you have allergic reactions to oils, lotions, and/or nuts? Yes_____ No_____

If yes, please explain:_____

Do you wear contact lenses? Yes_____ No_____

For Women: are you pregnant? Yes_____ No_____ If Yes, what week?_____

Agreement

Massage therapy is not a substitute for professional medical care or counseling. I do not diagnose or prescribe medications of any kind. I may refer you to another health care provider if you are experiencing a condition that is contradictory to massage therapy.

All information that is shared during the massage session is held strictly confidential.

Any no-show appointments or those cancelled with less than 24 hours in advance will be charged the full fee, no exceptions. If you arrive late, your session will end at the scheduled time and thus resulting in a shorter session. All returned checks will incur a \$25.00 late fee.

By signing below, I do hereby acknowledge that the above information that I provided is complete and accurate. I stated all my known medical conditions and medications and i will inform the massage therapist of any changes in my health status. I understand that the information that i provided is strictly confidential. I also understand that the scope of massage therapy practice and the policies listed above.

Signature:_____ Date:_____/_____/_____

Health Information (Check all conditions that apply to you, please explain)

General

Headaches____ Pain____ Sleep Disturbances____ Fatigue____ Fever____

Infectious____ Sinus____ Other____

Comments:_____

Skin Conditions

Rashes____ Athlete's Foot____ Warts____ Other____

Comments:_____

Allergies

Scents, Oils, Lotions____ Detergents____ Other____

Comments:_____

Muscles & Joints

Rheumatoid Arthritis____ Osteoporosis____ Scoliosis____ Spinal Problems____

Disk Problems____ Lupus____ TMJ, Jaw Pain____ Spasms, Cramps____

Sprains, Strains____ Tendonitis, Bursitis____ Stiff or Painful Joints____

Weak or Sore Muscles____ Neck, Shoulder, Arm Pain____ Low Back, Hip, Leg Pain____

Other____

Comments:_____

Nervous System

Head Injuries, Concussions____ Dizziness____ Ringing In Ears____ Chronic Pain____

Memory Loss, Confusion____ Numbness, Tingling____ Sciatica, Shooting Pain____

Depression____ Other____

Comments:_____

Respiratory / Cardiovascular

Heart Disease____ Blood Clots____ Stroke____ Lymphadema____ Swollen Ankles____
Irregular Heart Beat____ High/Low Blood Pressure____ Poor Circulation____
Varicose Veins____ Chest Pain, Shortness of Breath____ Other____

Comments:_____

Cancer / Tumors

Benign____ Malignant____ Other____

Comments:_____

Digestive / Elimination System

Bowel Dysfunction____ Gas, Bloating____ Bladder/Kidney Dysfunction____
Abdominal Pain____ Other____

Comments:_____

Endocrine System

Thyroid Dysfunction____ Diabetes____ Other____

Comments:_____

Reproductive System

Pregnancy____ Painful, Emotional, Menses____ Fibrotic Cysts____ Other____

Comments:_____

Habits

Tobacco____ Alcohol____ Drugs____ Coffee/Soda____ Other____

Comments:_____

CONTRACT FOR CARE: I promise to participate as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect My manual therapist to provide safe and effective treatment.

CONSENT FOR CARE: It is my choice to receive manual therapy and give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature_____ Date_____

Signature of a parent or guardian_____ Date_____

(If patient is a minor)

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. Please review it carefully.

HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

MY PLEDGE REGARDING YOUR MEDICAL INFORMATION

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situation, the law requires me to disclose your health information without either a written or verbal consent.

USE AND DISCLOSURE WITH CONSENT INFORMATION

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization

in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

USE AND DISCLOSURE WITHOUT CONSENT

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.

This notice is effective as of March 17th, 2003, and I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices from this office.

You have the right to file a formal, written complaint with me at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint.

For more information about my privacy practices:

Privacy Officer

Advanced Bodywork Therapy Inc.

19068 NW Jensen Way Suite 4B

Poulsbo ,Wa 98370

For more information on HIPPA or to file a complaint:

The US Dept of Health & Human Services

Office of Civil Rights

200 Independence Ave. SW

Washington DC 20201

877-696-6775 (toll free)

This notice has been issued and considered effective date signed. This copy shall be retained by the department for a minimum of six (6) years.

Signature of patient or Legal representative

_____ Date _____