Massage Haven! Client Information Form

All information is confidential. It will not be shared with or sold to any other company or parties.

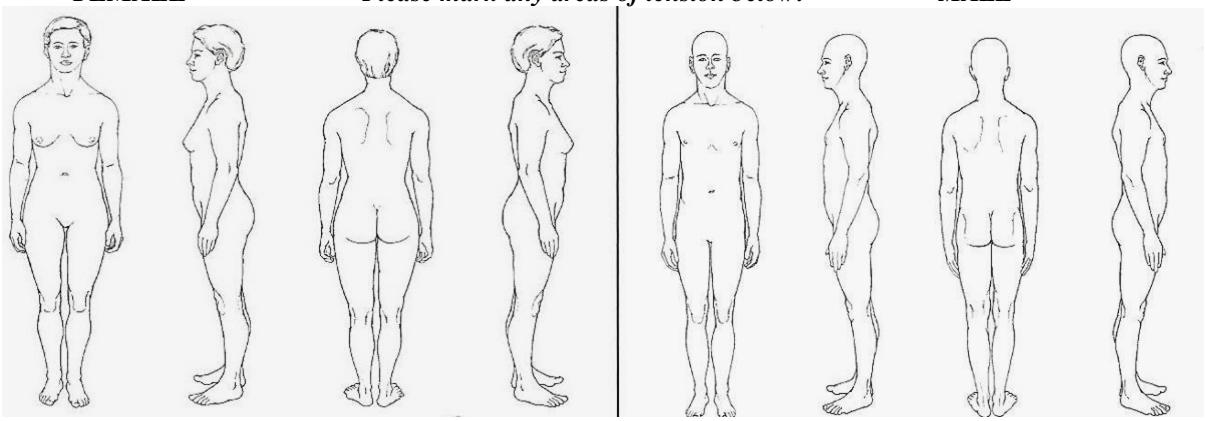
Name:_____Birthday:_____
Address:_____
City, State, Zip:_____
Home Phone:_____Work Phone:_____
Cell Phone:_____Email Address:_____@_____
Referred by:_____Occupation:_____
In case of emergency:_____Phone:_____

Massage Treatment Intake

Have you had a professional massage before?_____How recently?_____
Circle the primary purpose of today's visit? **Pain relief, Relaxation, Pampering, PIP other**_____
Any injuries in the past two years?_____For what/when?_____
Other medical condition, or are you taking medications I should know about?_____
_____

Please circle any symptoms/conditions that are current or have been present in the last six months: **Stress Headaches Pregnant Arthritis High blood pressure Varicose veins Contagious diseases Allergies Back pain Heart disease Head cold Breathlessness, Abdominal pain Digestion Problems Other**_____

FEMALE ***Please mark any areas of tension below:*** ***MALE***



Cirlce one: No Pain 0- 1 2-Mild 3 4-Nagging 5 6-Distressing 7 8-Horrible 9 10-Worst Possible
Do you wish to receive massage on the abdominal area? circle one YES NO

I understand that massage therapy is not a substitute for medical care and will seek care from a licensed medical provider when needed. I will also keep my massage therapist informed of any new conditions, injuries or illnesses that occur. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. By signing this form, I am giving my informed consent to receive massage therapy/spa services at Massage Haven .

Client Signature_____Date:_____

Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24 hour advance notice is required when canceling an appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you will be charged the **full amount** of your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show." They will be charged for their "missed" appointment.

Late Arrivals

If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time.

Client Signature_____Date:_____

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Law requires the privacy of your health information be maintained and that you are provided this notice of the legal duties and privacy practices with respect to your health information. Other than the uses and disclosures we described below, your health information will not be sold or provided to any outside marketing organization.

We must abide by the terms of this notice and we reserve the right to change the terms of this privacy notice. If a change is made, it will apply for all of your health information in our files, and you will be notified in writing.

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

USES AND DISCLOSURES

Here are examples of use and disclosure of your health care information:

1. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your session records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run this practice.
4. We may need to use your name, address, phone number, and your records to contact you to provide appointment reminder calls, recall postcards, Welcome and Thank You cards, information about alternative therapies, or other related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your information to specific individuals, companies, or organizations. Any restrictions should be requested in writing. We are not required to honor these requests. If we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your information without your consent or authorization in the following circumstances:

1. We are providing services to you based on the orders (referral) of a health care provider.
2. We provide services to you in an emergency and are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If your information has been released prior to your request to revoke your authorization. 165.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION

We will attempt to accommodate any reasonable written request regarding your contact information that has been provided by you.

AMENDING YOUR HEALTH INFORMATION

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

INSPECTING/COPYING YOUR HEALTH INFORMATION

You have the right to inspect the your files while in our office and/or have a copy made for you. The information is available up to seven years from the date that the record was created.

Your request to inspect or obtain a copy of the file must be in writing. There will be a charge of $.20 per page copied.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

Required for your session, to obtain payment for services, to run our practice, and/or made to you.

Necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.

For national security, intelligence purposes, or law enforcement officers.

That were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12-month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for further treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Bldg. Washington, DC 20201. This notice effective as of April 14, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

I, _____, give my permission for you to leave any information for me and use your name/clinic name at the following: Home phone _____ Work phone _____Cell phone_____

Client Name Printed Date _____Client Signature_____ Authorized Staff Person_____

Personal Representative Printed Personal Representative Signature _____

Description of personal representative's authority to act for the client:_____