Client Intake Form - Therapeutic Massage

Client Information

Name _____ Email _____

Phone (cell/day) _____ DOB _____ Age: _____

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by: _____

Health Information

Are you taking any medications? ☐ yes ☐ no If yes, please list: _____

Any allergies? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no If yes, please list: _____

Are you pregnant? ☐ yes ☐ no If yes, how many months: _____ Due date: _____

Are you you currently under medical supervision or receiving other medical interventions? ☐ yes ☐ no

If yes, please describe: _____

Areas of swelling	yes no	Diabetes	yes no	Osteoporosis	yes no
Autoimmune disorder	yes no	Fibromyalgia	yes no	Phlebitis	yes no
Back / neck problems	yes no	Headaches	yes no	Sciatica	yes no
Bleeding disorders	yes no	Heart condition	yes no	Seizures	yes no
Blood clots	yes no	Hypertension	yes no	Stroke	yes no
Bruise easily	yes no	Kidney disease	yes no	Tendinitis	yes no
Bursitis	yes no	Multiple sclerosis	yes no	TMJ disorder	yes no
Cancer	yes no	Neurological condition	yes no	Varicose veins	yes no
Contagious condition	yes no	Neuropathy	yes no	Vertigo / dizziness	yes no
Decreased sensation	yes no	Osteoarthritis	yes no		

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: _____

_____

Please describe any other injuries or health conditions: _____

_____

Massage Information

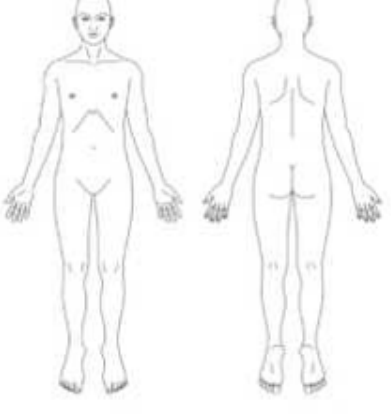
Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem

_____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Informed Consent

WellCome OM Integral Healing and Education Center, LLC, is a wellness center that houses a variety of health professional businesses. As a guest, you understand and agree that you are not being treated by WellCome OM Integral Healing and Education Center, LLC, but by the specific provider(s) you visit. WellCome OM Integral Healing and Education Center, LLC is not a health care provider. We recommend and encourage you to continue any treatment and medication that your doctor has prescribed and to continue with any medical care plan your doctor has recommended. Your signature below indicates you understand the stated fact and hold WellCome OM Integral Healing and Education Center, LLC harmless, and released from damages or liability.

Teachers, visiting lecturers, and providers are independent and do not necessarily represent the thoughts and ideology of WellCome OM Integral Healing and Education Center, LLC.

I understand that my record will be kept confidential and will not be released to others, unless they are involved in my care at WellCome OM Integral Healing and Education Center, LLC. I understand that I have the right to request restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or center operations. I understand that I may look at my records at any time, and I can request a copy.

While I understand that there have been no warranties, assurances, or guarantees of successful treatment made to me, I desire to undergo these healing modalities / treatment(s) offered at WellCome OM Integral Healing and Education Center, LLC after having considered the information contained in this document, the information provided to me through conversations with my treating physician, provider, and/or healthcare advisor, and through materials provided to me by WellCome OM Integral Healing and Education Center, LLC to educate me about the healing modalities / treatment(s). I acknowledge that I have had the opportunity to ask any questions of my physician with respect to the proposed therapy, and the procedures to be utilized, and all of my questions have been answered to my full satisfaction. I also acknowledge that I have received a copy of this informed consent.

I have read, understood, and agree to the foregoing. I have executed this Informed Consent freely and willingly, and understand its provisions. I recognize that WellCome OM Integral Healing and Education Center, LLC will rely upon my execution of this document in accepting me as a client. I hereby authorize and consent to healing modalities / treatment(s) by WellCome OM Integral Healing and Education Center, LLC. I acknowledge receipt of this Informed Consent.

Access to the WellCome OM Integral Healing and Education Center, LLC, (hereafter WellCome OM), is conditioned upon your acceptance and signature of the following:

By your signature below, you understand and acknowledge that WellCome OM is not your provider of services. All providers here at WellCome OM are independent contractors who maintain their own practice and are exclusively responsible for their treatment, therapies, and procedures. You further agree to hold WellCome OM harmless from any claims for damages or injuries that may arise from the services of any provider at WellCome OM and release us from any damage and/or liability therefrom.

It is the recommendation of WellCome OM that you continue with any medical care and treatment recommended by your treating physician and to check with them prior to altering or changing their prescribed instructions.

_____	_____
Printed Name	DOB
_____	_____
Signature	Date

Payment Agreement

Because many of the treatments used in complementary medicine are not recognized by consensus mainstream medicine, we cannot guarantee the amount or availability of coverage for our services and treatment under your health care insurance policy. You are responsible for the payment without regard to insurance coverage.

I have sought the services of WellCome OM Integral Healing and Education Center, LLC, its associates, employees, and staff. I understand this practice uses some diagnostic and treatment methods that are known as complimentary, alternative, and/or holistic and are not covered by insurance.

I fully understand that WellCome OM Integral Healing and Education Center, LLC, is a fee-for-service provider that **does not accept insurance, and payment for any services rendered is due at the time of service.**

Printed Name	DOB
Signature	Date

****

Acknowledgement of Receipt of:

Notice of Privacy Practices *and* Florida Patient's Bill of Rights and Responsibilities

I acknowledge that I have received a copy of the following documents:

- WellCome Om Integral Healing and Education Center, LLC, Notice of Privacy Practices
- Florida Patient's Bill of Rights and Responsibilities

Signature	Date

HIPAA OMNIBUS NOTICE OF PRIVACY PRACTICES

Effective Date: March 24, 2017

Your Information. Your Rights. Our Responsibilities.

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.**

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. ✧ We are not required to agree to your request, and we may say "no" if it would affect your care. • If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. ✧ We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care. • Share information in a disaster relief situation. • Include your information in a hospital directory. • Contact you for fundraising efforts. • *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: ✧ Preventing disease. ✧ Helping with product recalls. ✧ Reporting adverse reactions to medications. ✧ Reporting suspected abuse, neglect, or domestic violence. ✧ Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ✧ For workers' compensation claims. ✧ For law enforcement purposes or with a law enforcement official. ✧ With health oversight agencies for activities authorized by law. ✧ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a comment or complaint about our privacy practices by:

1) Mail to Corporate Privacy Officer, 4242 Lake in the Woods Drive, Spring Hill, FL 34607.

2) Email to youmatter@wellcomeomcenter.com;

3) Phone (352) 600-4242;

4) Written communication to the facility following the process outlined in our Company's Patient Rights documentation; and/or

5) Written communication to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You will not be penalized for filing a complaint.

Florida Patient's Bill of Rights and Responsibilities
Florida Statutes Chapter 381(026)

Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his or her rights, as stated in Florida law, through the grievance procedure of the health care provider or health care facility which served him or her and to the appropriate state licensing agency.
- A patient is responsible for providing to the health care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the health care provider.
- A patient is responsible for reporting to the health care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by the health care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the health care provider or health care facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the health care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her health care are fulfilled as promptly as possible.
- A patient is responsible for following health care facility rules and regulations affecting patient care and conduct.