MASSAGE INTAKE FORM

MILWAUKIE MASSAGE CENTER

3716 SE INTERNATIONAL WAY • MILWAUKIE, OR 97222 • 503-303-7144

Patient Name: _____ **Birthdate:** _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact Name: _____ Contact Info: _____

1. How are you feeling today on a scale of 1 to 10? (Scale: 1 is almost no pain and a 10 is worse pain you have ever felt)

   (Please circle) 1 2 3 4 5 6 7 8 9 10

2. Have you ever received a professional massage before? ☐Yes ☐No

   If yes, how recently? _____

3. What types of massage do you prefer? _____

4. What type of pressure? ☐Light ☐Medium ☐Firm

5. Do you like to have heat used on the table? ☐None ☐Medium ☐High

6. Are there any parts of your body that need special attention?

   _____

   _____

7. Do you have any areas that you **do not** want touched today (i.e., face, feet)?

   _____

8. What are your goals/expected outcomes for your massage today?

   _____

9. Please list your current symptoms or issues (i.e., stress, pain, stiffness, fatigue, etc.)

   _____

10. How do these symptoms interfere with activities of daily living (sleep, exercise, work)?

    _____

11. Are you pregnant? ☐Yes, # of weeks _____ ☐No

12. Are you feeling sick today with a fever, cough, or runny nose? ☐ Yes ☐ No

    If yes, how long have you felt this way and are you currently taking any medications?

    _____

13. What, if any, prescription medications do you take daily?

    _____

14. What health conditions are these medications for?

_____

15. Have you had any major recent surgeries, accidents or injuries? ☐ Yes ☐ No
    If yes, please describe the condition and approximate date of onset

_____

16. Are you wearing contacts today? ☐ Yes ☐ No

17. Do you experience vertigo when lying face down? ☐ Yes ☐ No

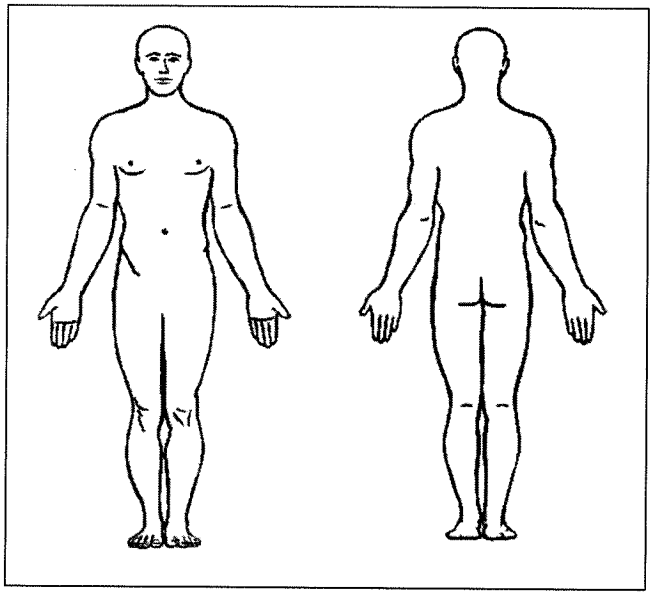
18. Are you sensitive or allergic to any scents like essential oil? ☐ Yes:_____ ☐ No

19. Do you have high or low blood pressure? ☐ Yes ☐ No

20. Is there any other information in your medical history that would be helpful for you therapist to know (i.e., heart attack, stroke, diabetes, epilepsy, cancer, etc.)

_____

Please circle the areas you would like to have worked on:



Signature _____ **Date** _____

THANK YOU AND ENJOY YOUR MASSAGE!

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.

The privacy of your medical information is important to us. We understand that your medical information is personal. We aim to provide you with quality care and to follow certain legal requirements. We also describe your rights and certain duties we have on the use and disclosure of medical information. We are required by law to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your rights on your medical information. We have the right to change our privacy practices and the terms of this notice anytime, given the changes are permitted by law. Before we make an important change in our privacy practices we will change this notice and make the new notice available to you upon request. Any specific written authorization you provide may be revoked by writing to us.

USE AND DISCLOSURE OF MEDICAL INFORMATION

Your protected health information may be used and disclosed by our office to others outside of our office who are involves in your care and treatment for the purpose of providing health care services to you, e.g., referrals to other physicians. Your protected health information may also be used and disclosed to pay your healthcare bills and to support the operation of the physician's practice, e.g., insurance companies often require chart notes for payment or authorization of treatment, managed care groups require release of information for physician performance evaluation.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION OR OPPORTUNITY TO AGREE OR OBJECT:

- **Required by law**: We may disclose your protected health information to the extent that the use or disclosure is required by law
- **Public Health**: Disclosure for public health activities and purposes to a public health authority, e.g., to prevent or control a disease.
- **Communicable Disease**: Disclosure pertaining to risk of contracting or spreading a communicable disease or condition.
- **Health Oversight**: Disclosure to agencies authorized by law such as government agencies, regulatory programs, etc. for audits, inspections, investigations, etc.
- **Abuse or Neglect**: Disclosure to a public health authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose this information if we believe you have been a victim of abuse, neglect or domestic violence to the government entity or agency authorized to receive this information and will be made consisitent with applicable state and federal laws.
- **Food and Drug Administration**: Disclosure for the purpose of quality, safety, or effectivness of FDA related products or activities.
- **Legal Proceedings**: Disclosure for judicial or administrative proceedings, in response to a court order, response to subpoena, discovery request or their lawful process.
- **Law Enforcement**: Disclosure for legal legal processes, limited information for identification and location purposes, pertaining to victims of a crime, suspicion that death has occurred as a result of criminal conduct, if a crime occurs on our premises, medical emergency (not on our premises) that it is likely a crime has occurred.
- **Coroners, Funeral Directors, Organ Donation**: Disclosure for identification purposes, cause of death or for the entity to perform their dutied authorized by law. Disclosure also for cadaveric organ, eye or tissue donation purposed.
- **Research**: Disclosure to researchers when approved by institutional review board which has established the research protocols to ensure the privacy of your protected health information.
- **Criminal Activity**: Disclosure consistent with applicable federal and state laws.
- **Military Activity and National Security**: Disclosure for Armed Forces personnel for activities deemed necessary by military command authorities, determination of eligibilty benefits by the Department of Veteran Affairs, foreign military authority if you are a member of that service. Disclosure to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation**: Disclosure as authorized to comply with workers' compensation laws and other similar programs.
- **Inmates**: Disclosure for correctional facilities.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT REQUIRE PROVIDING YOU THE OPPORTUNITY TO AGREE OR OBJECT:

Others Involved in Your Health Care or Payment for Your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it's in your best interest based on our professional judgement. We may use or disclose this information to notify or assist in notifying a family member, personal representative or any other person responsible for your care of your location, general condition or death. Finally, we may use or disclose this information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your health care.

YOUR INDIVIDUAL RIGHTS:

- **The Right to Inspect and Copy Your Protected Health Information**: You must make your request in writing and submit it to the contact listed at the end of this notice. If you request copies, there is a charge of $3.50 for each page, plus postage if you would like the copies mailed to you.
- **You Have the Right to Request a Restriction of Your Protected Health Information**: You may ask us not to use or disclose any part of your information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Policy Practices. Your request must state the specific restriction and to whom you want the restrictions to apply. This must be requested in writing. Your physician is not required to agree to a restriction, however, if they do agree that restriction may be voided for the purposes of providing emergency treatment.
- **You May Have the Right to Have Your Physician Amend Your Protected Health Information**: You may request an amendment in your health record. In certain cases we may deny this and you will have the right to file a statement of disagreement to which we may prepare a rebuttal and provide you a copy of any such rebuttal. Please inform the contact at the end of this notice for specific questions about amending records.
- **You Have the Right to Receive an Accounting of Any Certain Disclosures We Have Made of Your Protected Health Information**: This right applies to disclosures for which other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures made by you, if authorized by us, to make the disclosure to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement as provided in the privacy rule or correctional facilities, as part of a limited data disclosure.

QUESTIONS AND COMPLAINTS:

If you have any questions about this notice or think that we may have violated your privacy rights, contact the person named below. You must also submit a written complaint to the US Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Milwaukie Massage Center
3716 SE International Way
Milwaukie, OR 97222
(P) 503-659-0073 • (F) 503-659-7471

ACKNOWLEDGMENT FORM:

I acknowledge that I have reviewed, understand and agree to the Notice of Privacy Practices of Milwaukie Chiropractic Center.

SIGNATURE	DATE

FINANCIAL AGREEMENT AND CANCELLATION POLICY

Milwaukie Chiropractic and Massage Center

Thank you for choosing our office for your healthcare needs. We respect and understand that you have the choice of going anywhere for treatment to improve your function and help with pain and dysfunction.

We have been blessed with being able to attend to our communities needs for over 30 years and with that blessing we have become a busy office.

All our doctors and massage therapists have a busy daily schedule with patients who are trying to schedule an appointment even on the same day. When someone schedules an appointment and fails to call in to cancel, availiblity was taken away from someone who wanted that appointment time.

Because of this need; we have developed a cancellation policy.

We now require an advance notice of at least 24 hours if you need to cancel your appointment.

If you are late, you will have the time remaining on your scheduled appointment. Extensions may not be possible. You are still required to pay the full amount for the service.

There will be a $25.00 fee for a no-call or no show or a late chiropractic appointment cancelation. For massage, a 24 hour notice is required, otherwise there will be a $50 fee for a 60 minute massage, and $75 fee for a 90 minute massage appointment. Insurance will not cover no-call, no-show or late fees.

You will be billed for any service amount owing and balance is due by the 10th of the following month. Failure to pay will result in no future appointments being made without pre-payment and/or collections actions.

We respect your time as we hope you respect ours. Thank you for understanding.

With All Due Respect,
The Entire MCC & MMC Staff

SIGNATURE	DATE

MY SIGNATURE IS AN ACKNOWLEDGMENT THAT I HAVE READ THE ABOVE STATEMENT

INFORMED CONSENT FOR MASSAGE THERAPY

MILWAUKIE MASSAGE CENTER
3716 SE INTERNATIONAL WAY • MILWAUKIE, OR 97222 • 503-659-0073

I understand that the massage given to me by therapist at Milwaukie Massage Center is for the purpose of stress reduction, pain reduction, relief from muscle tension, and/or increasing circulation.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder or does not prescribe medical treatment or pharmaceuticals, I also acknowledge that spinal manipulations are not part of massage therapy. I clearly understand that massage therapy is not a substitute for medical examination. I understand that it is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me about the results of the treatment. I acknowledge that as with any treatment there can be risks and those have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided to me and disclosed to the therapist any medical conditions affecting me. I understand that it is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers if required.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and additional treatment if proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

Patient Name: _____

Signature: _____ Date: _____

Therapist: _____ Date: _____

WHAT TO EXPECT ON YOUR INTIAL VISIT TO MILWAUKIE MASSAGE CENTER

Please arrive 15 minutes early to fill out paperwork in your massage history and state of current conditions. You can also download our paperwork by clicking on the link and come in with your paperwork completed. We will need a copy of your photo ID along with the intake form, policy and procedures, and HIPPA privacy form.

At the start of your appointment, your massage therapist will call your name and introduce themselves. Once ready you will proceed back to one of our massage rooms and look over your intake to discuss what you would or would not like from your massage. This is also a good time to tell your therapist about any areas that need attention or places you prefer to not be touched, such as your feet or face. Also, this is a suitable time to alert your therapist if you have any cuts, bruises, or are on any blood thinning medications such as Coumadin.

Your therapist will then exit the room and give you time to get undressed to your comfort level and get under the sheet.

A 90-minute massage session includes an 80-minute massage with 5 minutes to get on the table and 5 minutes to get dressed and exit the room. Likewise, a 60-minute massage session includes a 50-minute massage with time to get on and off the table, and a 30-minute massage session includes a 20-minute massage with time to get on and off the table.

After massage when you come out of the room you will be greeted by your therapist with a cup of water and expect information on possible stretches, self-care, and when you should return for follow-up care.