

ABSOLUTE WELLNESS CENTER

Massage Intake Form

Name _____

DOB _____

Address _____

Home # _____ - _____ - _____

Work # _____ - _____ - _____

Cell # _____ - _____ - _____

Email Address _____

___ I hereby authorize the release of medical information necessary to process my insurance claim. This may include intake forms, chart notes, reports, correspondences, billing statements and any other information to my attorneys, health care providers and insurance case managers.

___ I am responsible for all charges for all services provided. In the event that the insurance company denies benefits or makes a partial payment, I am responsible for any balance due. This may not apply to insurance companies that I am under contract with.

___ I understand the benefits and risks of massage and give my consent for massage. I will consult my practitioner with any questions or concerns immediately.

___ I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.

___ NOTE: Massage therapists are allowed to accept cash tips for excellent service. This is optional and may be given directly to the therapist on duty.

___ I agree to pay a \$20 deposit for each massage appointment made OR leave my credit card # on file with Absolute Wellness Center. I agree to provide **24 hour** cancellation notice. If I fail to do so, I understand and agree that I will lose my \$20 deposit and be billed for the balance of the entire massage session OR my credit card on file will be charged \$65. (Please note that insurance companies **do not** pay this, you do.) In the event that the charge is declined I understand I will be billed \$65 payable within 10 days of receipt.

Signature _____

Date _____

VISA/MASTERCARD/DISCOVER (circle one)

Card # _____

Exp _____

3-digit code _____

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Massage Intake Form (cont'd)

Name _____ Date of Birth _____

Please answer the following questions by circling the appropriate answer:

- Have you ever had a professional massage before? YES NO
Do you have any skin problems or allergies? YES NO
Do you have arthritis or joint disorders? YES NO
Do you have any spinal problems? YES NO
Do you have varicose veins or blood clots? YES NO
Do you have any heart problems? YES NO
Do you smoke? YES NO
Do you exercise or participate in any sports? YES NO
If so what kind & how often? _____
Are you presently taking any drugs or medications? YES NO
Are you pregnant? YES NO
Are you nursing? YES NO
Do you have any kind of medical condition I should be aware of (such as cancer, diabetes, high blood pressure) before the massage? YES NO

If yes please specify: _____

Provisions of the massage
During your massage the therapist may use Swedish, deep tissue, cross fiber, trigger point, myofascial release, repetitive Use Injury Therapy or other approved techniques to facilitate the massage, excluding any contraindicated areas. The therapist will not work the breast area without written consent by the client. Proper draping will be used throughout the massage. If at any time the client is uncomfortable with the massage, the therapist will discontinue the massage.

Patient _____ Date _____

Therapist _____ Date _____

CLIENT'S WAIVER

Massage Therapy is not a substitute for medical examination and diagnosis. It is recommended that I see a physician for any medical ailment that I might have. I understand that the massage therapist does not diagnose illness, disease or any other physical or mental disorder. Likewise, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor perform spinal adjustments. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and understand that there shall be no liability on the massage therapist's part should I fail to do so.

Signature _____ Date _____