Lower Bucks
Total Health and
Wellness Center, P.C.

NEW MASSAGE PATIENT INTAKE FORM

Name____**Date**______________________

Address____

Date of Birth______________________________**Phone Number**____

Email Address____

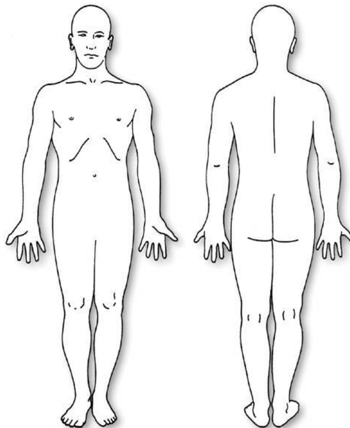
Emergency Contact____**Phone Number**________________________

Referred By (*If Applicable*)____

Is your condition due to a motor vehicle or work related accident? YES / NO
If Yes, have you filed a claim with your auto insurance or worker's compensation? YES / NO

Attorney's Name (*if applicable*)_____________________________________**Telephone**____________________

Mark an X where you have any pain or other symptoms



Please describe when and how your problem began below

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Are you presently taking any medications? YES / NO *(If yes, please list them below)*

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Have you had a recent injury or major surgical procedure? YES / NO *(If yes, please list them below)*

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Circle any of the following conditions that apply to you, past and present.
If needed, please add your comments to clarify the condition.

Headaches
Joint stiffness / Swelling
Spasms / Cramps
Broken / Fractured bones
Strains / Sprains
Back, hip pain
Shoulder, neck, arm, hand pain
Leg, foot pain
Problems walking
Jaw pain / TMJ
Tendonitis
Bursitis
Osteoarthritis
Osteoporosis
Rheumatoid Arthritis
Dizziness
Shortness of breath
Fainting
Cold feet or hands
Cold sweats
Heart condition

Indigestion
Constipation
Intestinal gas / Bloating
Diarrhea
Irritable bowel syndrome
Crohnøs Disease
Colitis
Numbness / Tingling
Fatigue
Sleep disorders
Ulcers
Paralysis
Herpes / Shingles
Cerebral Palsy
Epilepsy
Sciatica
Multiple Sclerosis
Muscular Dystrophy
Parkinsonøs Disease
Stroke
Pregnancy

Rashes
Scoliosis
Allergies
Athleteøs foot
Impetigo
Hemophelia
Tuberculosis
Chest, ribs, abdominal pain
Loss of Appetite
Depression
Difficulty concentrating
Hearing Impaired
Visually Impaired
Diabetes
Fibromyalgia
Plantar Fasciitis
Cancer
Low blood pressure
High blood pressure
Asthma
Other _______________

I understand that a massage therapist does not diagnose disease, illness, or prescribe any treatment or medications, nor do they provide spinal manipulation. I understand that my massage therapist may end the session for any inappropriate behavior. I have stated all of the conditions that I am aware of, and this information is true and accurate. I will inform my massage therapist of any changes in my health status and conditions going forward from today.

Client's Signature_______________________________ **Date**_______________________

CONSENT FOR THERAPY AND WAIVER OF LIABILITY

I, the undersigned client, hereby freely consent to receipt of massage services at Lower Bucks Total Health and Wellness center, P.C.

Client agrees as follows

Client understands and agrees that they will provide massage therapist with complete and accurate health information and, if requested by massage therapist, a written referral from clientøs primary healthcare provider if they are currently receiving care or has a specific medical condition or symptoms for which client takes medication or receives periodic evaluations or treatment. Client understands that massage therapy is designed to be an ancillary health aide and is not a suitable form for primary medical treatment for any condition.

1. Client and massage therapist have discussed the potential benefits and possible side effects of massage therapy and have agreed upon a course of focused attention and manual therapy for the predetermined goals of stress reduction, relief of muscular discomfort and/or promotion of general health. Client has been given an opportunity to ask questions to the therapist and has received all requested information.

2. Client understands that the unclothed body will be draped at all times for warmth, sense of security and as a mark of massage therapy professionalism. Client agrees to immediately inform massage therapist of any unusual sensation or discomfort so that the application of pressure may be adjusted to their level of comfort. Client understands that massage therapy is not sexual in any manner and that any illicit or suggestive remarks or behavior on the clientøs part will result in an immediate termination of the therapy session. Client understands that payment will be expected in full regardless of whether the massage is completed or not.

3. Client hereby assumes full responsibility for receipt of the massage therapy and releases and discharges both massage therapist and Lower Bucks Total Health and Wellness Center, P.C. from any and all claims, liabilities, damages, actions or causes of action arising from the therapy received hereunder including, without limitation, any damages arising from acts of active or passive negligence on the part of the massage therapist to the fullest extent allowed by law.

4. Client, in signing this consent for Therapy and Waiver of Liability (õConsentö), understands and agrees that this consent will apply to and govern the current and all future therapy sessions performed by their massage therapist here at Lower Bucks Total Health and Wellness Center, P.C.

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Client's Name (print)

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Client's Signature **Date**

Parent/Guardian **MUST** sign for all clients under 18 years of age

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Authorized Facility Signature **Date**

Lower Bucks
Total Health and
Wellness Center, P.C.

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.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health information to other health care professionals within our practice for the purpose of treatment, verifying insurance benefits, payment and/or health care operations.

example

On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Lower Bucks Total Health and Wellness Center, P.C.

It is our policy to provide a substitute health care provider, authorized by Lower Bucks Total Health and Wellness Center, P.C. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to sickness, vacation or an emergency situation.

Payment

We may disclose your health information to your insurance provider for the purposes of payment or health care operations.

example

"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Lower Bucks Total Health and Wellness Center, P.C. for health care services rendered. If you pay for your health care services personally, we will, as a courtesy to you, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services rendered."

Workers’ Compensation

We may disclose your health information as necessary to comply with State Worker’s Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons

We may disclose your health information to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Appointment Reminders

As a courtesy to our patients, we may send you appointment reminders in the forms of phone calls, text messages or emails. If we call and you are not there or you do not answer, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed in any of these reminder formats other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Fundraising and Marketing

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc throughout the year. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, dates and times and request your participation in such events. It is not our policy to disclose any personal health information about your condition for the purpose of Lower Bucks Total Health and Wellness Center, P.C. sponsored fundraising events."

Change of Ownership

In the event that Lower Bucks Total Health and Wellness Center, P.C. is sold or merged with another organization, your health information will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to your requested restriction(s).

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information

- You have a right to request that Lower Bucks Total Health and Wellness Center, P.C. amend your protected health information. Please be advised, however, that Lower Bucks Total Health and Wellness Center, P.C. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

- You have a right to receive an accounting of disclosures of your protected health information made by Lower Bucks Total Health and Wellness Center, P.C.

- You have the right to request a paper copy of this Notice of Privacy Practices at any time.

Changes to This Notice of Privacy Practices

Lower Bucks Total Health and Wellness Center, P.C. reserves the right to amend this Notice of Privacy Practices at any time in the future and will make provisions effective for all information that it maintains. Until such amendment is made, Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to comply with this notice.

Lower Bucks Total Health and Wellness Center, P.C. is required, by law, to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice, or if you want more information about your privacy rights, please call Charles Flood, D.C. at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by phone within 2 working days.

Complaints

Complaints about your privacy rights or how Lower Bucks Total Health and Wellness Center, P.C. has handled your health information should be directed to Charles Flood, D.C. at 215-788-3608. If Charles Flood, D.C. is not available, you may make an appointment for a personal conference in person or by phone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS
Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of

__11__/__1__/__14__

I have read the Privacy Notice and understand my rights contained in this notice. By way of my signature, I provide Lower Bucks Total Health and Wellness Center, P.C. with my authorization and consent to use and my disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

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Patient's Name (print)

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Patient's Signature **Date**

Parent/Guardian **MUST** sign for all patients under 18 years of age

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Authorized Facility Signature **Date**