Patient/Client Intake Form

Last Name:	First Name:	DOB:	Age:
Street Address:	City/State	Zip:	
Email Address:	Phone:		
Emergency Contact:	EC Phone:		
Who can we thank for this referral?			

Medical History

What is the reason(s) for your visit today, and what goals do you have for physical/massage/wellness therapy?

Was this condition related to an accident or injury?

□ No □ Auto □ Work-related □ Other (please indicate)

□ Attorney name/number:

Brief explanation of the injury:

Please check any health related issues that you currently have or have had in the past.

□ Heart/cardiovascular disease (heart attack, stroke, CHF)
□ Respiratory disease (pneumonia, emphysema, tuberculosis, asthma)
□ Epilepsy/convulsions
□ Anemia or blood disorders
□ Thyroid disorders
□ Arthritis (osteo, inflammatory)
□ Back pain/injury
□ Surgical implants
□ Bowel/bladder issues
□ Congenital Abnormalities
□ High or low blood pressure
□ Eczema/skin conditions
□ Immune disorders
□ Pacemaker or defibrillator
□ Headaches
□ Hepatitis
□ Tumor or cancer
□ Hernia/repair
□ Pregnant/nursing
□ Neck pain/injury
□ HIV/AIDS

Any other medical conditions we should be aware of?

Allergies: □ Latex □ Adhesive □ Lotions/soaps □ Medications □ Other (explain)

Surgical History:

Medications:

Date:

For Massage Clients Only

Have you ever experienced a professional massage or bodywork? □ Yes □ No

What did you like or not like about your previous experience?

What type of pressure do you like? □ Light □ Moderate □ Deep

Therapeutic massage: involves many techniques including but not limited to effleurage, friction, vibration, percussion, and petrissage. All parts of the client's body may be massaged with the exception of the male and female genitals and the female breasts. You may ask your therapist to avoid certain areas or techniques during your massage. Additionally, your therapist may decide that certain techniques may be contraindicated based on your medical history, or may require increased attention due to your medical history.

Draping: Draping will be maintained throughout the session. If you are uncomfortable at any point during the massage, please notify your therapist immediately.

Type of massage requested:
□ Deep Tissue □ Relaxation/Swedish □ Prenatal □ Myofascial □ Reflexology

Any specifics?
Areas to be avoided:

Areas needing focused attention:

As the client, I understand that massage is for the purpose of relaxation and release of muscular tension and is not a substitute for medical diagnosis or intervention. I understand that I should see a medical professional for any mental or physical condition or ailment of which I am aware. I am voluntarily using Elevate Wellness Studio facilities and services, and I agree, to the fullest extent permitted by law, to forever release, indemnify, defend, and hold harmless Elevate Wellness Studios, its affiliates, their respective agents, offices, directors, owners, contractors, and employees from any and all claims and causes of action which I might otherwise have or be entitled to assert as a result of or related to any physical injury or otherwise, including without limitation death or property damage or loss sustained in connection with my use of the wellness facilities or participation in any wellness program or treatment, including without limitation, claims and causes of action based on negligence, breach of warranty, or breach of contract. I also agree to indemnify, defend, and hold harmless the Released Parties from any and all claims brought by their arising out of any acts, errors, or emissions.

Client (or Parent/Guardian) Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

Consent for treatment of a Minor under the age of 17: By signing below, I hereby authorize a Licensed or Registered Therapist to administer massage, facial, or bodywork therapy techniques to my child/dependent as they deem necessary. The release statement above is understood to include the minor being treated at Elevate Wellness Studio facilities and all release of liability statements above apply to the minor and his/her treatment.

Parent or Guardian Signature: **Date:**

Date:

Fees and Insurance

Fees for services will be collected at the time of service. We do not submit any insurance paperwork to your insurance company. I understand that payment is expected at the time of service and that Elevate Wellness Studio will not submit any claims to my insurance company.

If you have **Medicare**, in order to receive care at this facility, you are agreeing to receive wellness and fitness services, which are not covered services by Medicare. As a result, you cannot submit a claim to Medicare for reimbursement. I understand, that if my insurance is Medicare, I will not send any claims to Medicare for this service, as it is not a covered service.

Patient/Client/Guardian Signature: **Date:**

Cancellation/No Show Policy

Cancellation/No Show Policy for Therapy Appointment: As a courtesy to all of our providers and clients, we have a 24 hour cancellation policy. If you do not cancel at least 24 hours in advance, your credit card will be charged 50% of the cost of scheduled service. If you do not call to cancel and do not show up for a scheduled appointment, we will charge the credit card on file 100% of the cost of scheduled service.

We understand that delays can happen when coming to Elevate, however, we always try to keep the other clients and therapists on a timely schedule. If you are late to an appointment, then the time with your therapist will be shortened to accommodate the next scheduled client. Fee schedules will not be altered for late appointments.

I understand and acknowledge the Elevate Cancellation and No Show Policy as stated above. I understand that I may have an abbreviated appointment time if I am late to an appointment, but the fee for the visit will not be altered.

Patient/Client/Guardian Signature: **Date:**

HIPAA Compliance

I hereby acknowledge that I have been presented with a copy of Elevate, LLC Notice of Privacy Practice. By signing this form, I acknowledge that I have reviewed this consent and agree to Elevate, LLC use and disclosure of my protected health information for treatment, payment, and health care operations.

Print Name:_____

Patient/Client/Guardian Signature: **Date:**

Agreement for Establishment of Services

I hereby give my permission for authorized personnel of Elevate, LLC to perform all necessary procedures and treatment for the delivery of Elevate, LLC Services. I understand that there may be circumstances beyond the control of Elevate, LLC when there may be an interruption of services. I give my permission of Elevate, LLC to release and receive medical records and information pertinent to my care. I also understand that Elevate, LLC will not be responsible for any lost or stolen items or any accidental injuries to me while I am on the premises, including interior or exterior of the property. A photo static copy of this authorization is valid as the original.

Print Name:_____

Patient/Client/Guardian Signature: **Date:**