bloomington wellness center

Twin Cities Scoliosis Center

952.881.2800 office
5143 w 98th st
bloomington, mn 55437
bloomingtonchiro.com

Massage Client Intake

Client Name: _____ Birth date: _____

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

Phone: _____ Email: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Have you had a massage before? ❑ Yes ❑ No

What was your favorite part of your last massage? _____
What was your least favorite part of your last massage? _____

Have you had any recent illnesses, injuries, surgeries, or skin rashes? Any allergies or sensitivities? Please explain: ____
_____

Are you currently under the care of a medical professional? Are you currently taking any medications or supplements? Please explain: _____
_____

Female Clients: Are you pregnant? ❑ Yes ❑ No If yes, what week? _____
Have you had any complications or is this a high risk pregnancy? _____

Are there any health or medical concerns of which we need to be aware? Any cuts, scrapes, bruises, etc. we should avoid? _____

What expectations do you have for your treatment today? What specific areas would you most like to focus on during the massage treatment? _____
_____

Please feel comfortable letting us know, anytime, any change you desire in temperature, pressure, etc. We are grateful you have chosen us for your therapeutic massage needs. We are here to help you feel better.

Cancellation/Missed Appointment Policy - *A 24 hour notification is required for appointments that need to be cancelled. If proper notification is not given, a $30 charge will be applied to your account and is due within 15 days of the missed/cancelled appointment.*

The information provided here is accurate and complete to the best of my knowledge. I will inform the Massage Therapist of any changes prior to my next service. I understand that I am receiving massage at my own risk and hereby release the Massage Therapist and Bloomington Wellness Center from any liability. I understand the Massage Therapist does not diagnose diseases or illnesses, nor prescribe medical treatment. I understand that a massage can be refused for any reason. I agree to pay for all services at the time they are rendered.

Signature: _____ Date: _____

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HIPAA Form

Patient Name _____

To the Patient – Please read the following statements carefully:

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare and practice operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Cory Emberland, DC
Telephone: 952-881-2800 **Fax:** 612-605-2788 **E-mail:** info@wellbloomington.com
Address: Bloomington Wellness Center, PA, 5143 W 98th Street, Bloomington, MN 55437

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, heath care and practice operations. I also acknowledge that I have received a copy of, and agree to, Bloomington Wellness Center, PA's Notice of Privacy Practices.

Signature _____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it.