SAGE

Pain & Recovery Alternatives

THERAPEUTIC MASSAGE

First Name_____ Last Name_____ Gender_____
Address_____ City/Zip_____
Phone_____ Date of Birth_____
Email_____
Emergency Contact Name & Phone_____
Referred by:_____

All information will be kept confidential. Are you under a health practitioner's care at this time (including physician, chiropractor, physical therapist, psychotherapist, alternative practitioner, etc.)?
If yes, for what condition?_____
Are you taking any medications?_____ If yes for what?_____

Do you have now, or have you ever had, any of the following?

_Heart Disease
_High Blood Pressure
_Anemia
_Emphysema
_Tuberculosis
_Asthma
_Seizures
_Migraine Headaches
_Stroke

_Diabetes
_Low Blood Sugar
_Phlebitis
_Blood Clots
_Kidney Disease
_Liver Disorder
_Hernia
_Ulcers
_Diverticulitis
_Thyroid Disorder

_Neck/Back Problems
_Paralysis
_Arthritis
_Osteoporosis
_Allergies
_Cancer
_Hepatitis
_Herpes
_HIV
_Severe depression

Have you been bothered with any of the following in the last 6 months?

_Chest Pains
_Chronic Bronchitis
_Sinusitis
_Head Colds, Flu, Fever
_Dizziness
_Dental Problems
_Urinary Disorder
Are you pregnant?___
Do you wear contacts?___

_Muscle Cramping
_Lack of Coordination
_Swollen Ankles
_Loss or Gain in Weight
_Bruise Easily
_Abdominal Pain
_Recurring Indigestion
_Constipation/Diarrhea

_Varicose Veins
_Depression
_Frequent Headaches
_Eye Strain
_Menstrual Problems
_Skin Disorder
_Inflammation (tendonitis, bursitis)
_Open sores/wounds

Have you had massage therapy/body work before?_____
What healthy lifestyle/stress reduction activities are you currently practicing? _____
_____
What healthy lifestyle activities are you interested in? _____
_____

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Describe any other present conditions, symptoms, or diagnosed diseases that you have at this time:_____

_____

Describe any significant bodily injuries that you can remember and when they happened (like accidents, sprains, falls, bone fractures, other): _____

_____

List hospitalizations and surgeries:_____

_____

Do you have a condition that you want addressed by massage therapy? (Describe condition)

_____

_____

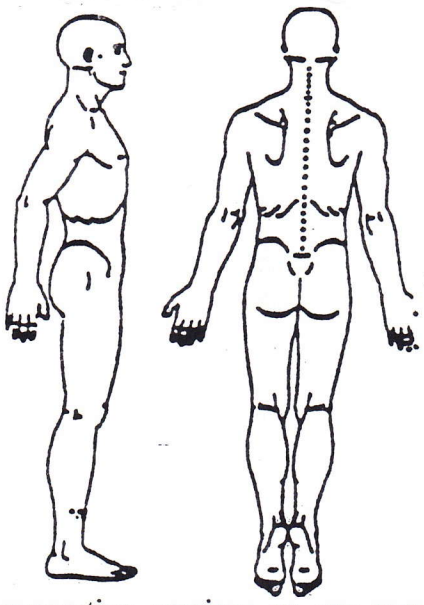
_____

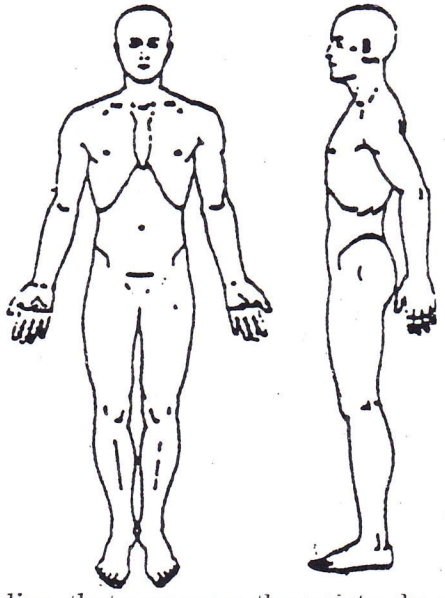
What are your goals/expectations of receiving a massage? (relaxation, stress reduction, specific condition addressed?) _____

_____

_____

On the figures below, please mark or shade in any areas of muscle or joint pain or stiffness.





I am requesting services on my own initiative and I realize that massage therapists do not diagnose ailments or prescribe treatments and that the request for the information above does not imply, in any way, the practice of medicine or diagnosis of a client's condition by the massage therapist. I , therefore, release the massage therapist from any liability for claims resulting from the use of their services.

SIGNATURE_____ DATE_____

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AUTHORIZATION FOR MASSAGE TREATMENT

I, _____, request and consent to the performance of massage therapies by Sage Health Group, LLC doing business as Sage Pain & Recovery Alternatives.

I understand that massage in not intended to replace conventional medical treatment and that any diagnosis of my condition(s) must be performed by a licensed physician, chiropractor or physical therapist.

I understand that massage involves the physical manipulation of muscles to address pain and soft tissue injuries. I understand that if I am required to remove clothing, I will be appropriately draped for privacy. As part of my treatment, I understand that the massage therapist may perform adjunct treatments such as cupping, Kinesio taping, gua-sha, and aromatherapy.

I realize there are risks and potential side effects caused by massage including bruising, lightheadedness, headaches, and muscle soreness. Usually side effects dissipate within 48 hours. I do not expect the massage therapist to be able to anticipate and explain all risks and complications, and I wish to rely on the massage therapist to exercise judgment during the course of my treatment which he or she feels, based upon the facts known, is in my best interest. I will immediately notify Sage Pain and Recovery Alternatives of any negative side effects or problems that I experience.

By signing below, I acknowledge that I have been told the potential risks associated with massage and I have had the opportunity to ask questions. I intend for this consent and release to cover the entire course of my treatment for my present condition and any future condition(s) for which I seek treatment.

With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been made to me by Sage Pain and Recovery Alternatives or any individual therapist regarding the improvement of my injury or condition(s).

I understand that any fees for treatment are payable at the time service is rendered.

I agree to give **24 hours notice** if I need to cancel an appointment. I understand that without advance notice, Sage Pain and Recovery Alternatives reserves the right to charge me a $50.00 fee for the missed appointment. Insurance companies will not reimburse me for missed appointments. Exceptional circumstances will be considered.

_____ _____
Signature of Patient Date

_____ _____
Signature of Person Authorized to Consent Date

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Pain & Recovery Alternatives
7116-C Six Forks Rd., Raleigh, N.C. 27615

Authorization for disclosure of health information and direct contact

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, we understand that we have, and always will, respect the privacy of your health information.

Disclosures of protected health information

Listed below are several reasons for having to use or disclose your PHI (personal health information)

- We may have to disclose your information to another healthcare provider or hospital should we refer you to them for a diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and /or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or operational purposes.

Your right to limit uses of disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we will respectfully request that you submit these restrictions in writing. With your right to restriction, you also have the right to revoke your authorization or consent to us at any time. Again, this change of authorization is requested in writing before your file status will be changed.

ESTABLISHED PATIENTS: We have a more complete notice that provides a detailed description of how your information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520) and is available upon your request. Please sign below to confirm this for has been gone over with you.

NEW PATIENTS: In your packet of new patient information you will find our Notification of Patient Privacy Policy. Please sign below to confirm that you have received it.

Authorization and permission

In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow up of health care, insurance coverage's/benefits issues or any other information that only the patient will personally be able to answer.

Below, please authorize any person(s) that we may discuss your treatment/finances with or that we may release your medical records to. Those listed below will also have your permission to schedule or change appointments on your behalf as needed.

Person 1:_____

Person 2:_____

Is there a way you would prefer for us **NOT** to contact you? yes/no
If you circled yes, please let us know how **NOT** to contact you: _____

Patient Signature_____Date_____

Print Name_____DOB_____Chart #_____