

**Lynnwood Family Massage Policy**

Welcome to Lynnwood Family Massage! The following is an explanation of our office policies and procedures. We believe that a clear understanding will allow us both to concentrate on the most important issue: regaining and maintaining your health. We are happy to answer any questions that you may have and are grateful to be at your service.

I understand that it is my choice to receive massage therapy and that massage therapists do not diagnose or prescribe. I agree to communicate with my practitioner regarding any changes in my insurance plan or financial circumstances. I further agree to communicate with my practitioner any time I feel my well-being is being compromised.

I understand that massage therapy is used to reduce stress, muscular tension, and pain. I understand there are no guarantees for recovery and if I am unsatisfied with the progress made with my treatment I will inform the therapist, so he/she may direct me to another treatment. However, I am financially responsible for the services rendered.

The procedure time for your treatment is 45-60 minutes. When you schedule, one full hour is set aside specifically to meet your needs. We do not double-book appointments and are unable to place another client in your space without sufficient prior notice. Therefore, it is imperative that you arrive 15 minutes prior to your appointment.

**CANCELLATION POLICY**

Our time is valuable, too. Cancellation notice is required **24** hours prior to your treatment time. **24** hours allows us to make your time slot available to another client in need of treatment. If sufficient notice is not given, and we are unable to fill your time slot, there will be a $40.00 charge to the credit card you enter below.

**\*\* We are unable to bill your insurance for cancellation fees. It is solely your responsibility. \*\***

Card number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Exp. Month/Year:\_\_\_\_\_\_\_\_\_\_**\_/\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full name on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY SIGNATURE INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE.**

CLIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINTED NAME: \_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lynnwood Family Massage Confidential Information**

NAME: BIRTHDATE / /

Please answer the following questions by circling YES or NO and provide any necessary clarifications.

|  |  |  |
| --- | --- | --- |
| YES YES | NO NO | Have you ever had a professional massage?  Do you exercise regularly or participate in any sports? What kind and how often? |
| YES | NO | Are you currently under the care of any other health care provider for a specific |
|  |  | condition? |
| YES | NO | Do you take any vitamins, minerals, or medication (including aspirin or ibuprofen) |
|  |  | Please list medication, dosage, and condition |
| YES | NO | Have you ever had surgery? Please list date(s) and procedure(s) |
| YES | NO | Do you have or have you ever had cancer? What type and when? |
| YES | NO | Do you have or have you ever had heart problems? Please explain: |
| YES | NO | Do you have high or low blood pressure? Please circle one. |
| YES | NO | Do you have varicose veins, blood clots or any other circulatory conditions not |
|  |  | mentioned? Please explain: |
| YES | NO | Do you have diabetes? How is it controlled? |
| YES | NO | Do you have arthritis? Osteoarthritis or Rheumatoid? (please circle one) |
| YES | NO | Where is it located?  Do you have bone or joint problems? Please describe: |
| YES | NO | Do you experience prolonged episodes of depression or other emotions? |
| YES | NO | Do you have any infections or contagious diseases? Please explain: |
| YES | NO | Are you experiencing any sleep disorders or changes in normal sleeping patterns? |
|  |  | Please explain: |
| YES | NO | Are you pregnant? What stage? |
| YES | NO | Do you wear contacts, dentures, or hearing aids? |
| YES | NO | Do you have any other medical conditions your therapist should be aware of before you |
|  |  | receive massage? |
| YES | NO | Do you have any needs that require special attention? Please explain: |

**Please read carefully, sign, and date.**

I understand that massage therapists do not diagnosis illness, disease or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that is recommended that I see a physician for any ailment I may have. I have stated all my known medical conditions and I am responsible to inform my massage therapist of any changes in my physical or mental health. I understand that my massage therapist is an independent contractor at Lynnwood Family Massage. I indemnify and hold harmless Lynnwood Family Massage from any loss or liability arising from services provided by my massage therapist.

SIGNATURE

DATE / /

**Lynnwood Family Massage Patient Registration**

LAST NAME: FIRST NAME: M.I.

BIRTHDATE: / /

ADDRESS

CITY: STATE: ZIP CODE:

CELL# - - HOME# - - WORK# - -

EMAIL:

PLEASE CIRCLE ONE: SINGLE - MARRIED - DIVORCED - WIDOWED – OTHER

EMPLOYED? FULL TIME / PART TIME STUDENT? PART TIME / FULL TIME

SCHOOL / EMPLOYER:

EMERGENCY CONTACT: # - -

HOW WERE YOU REFERRED TO LFC?

WOULD YOU LIKE US TO VERIFY YOUR MASSAGE THERAPY BENEFITS?

PRIMARY INSURANCE:

SUBSCRIBER NAME: BIRTHDATE / /

SUBSCRIBER EMPLOYER: \_

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX)

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

\*SECONDARY INSURANCE:

SUBSCRIBER NAME: BIRTHDATE / /

SUBSCRIBER EMPLOYER: \_

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX)

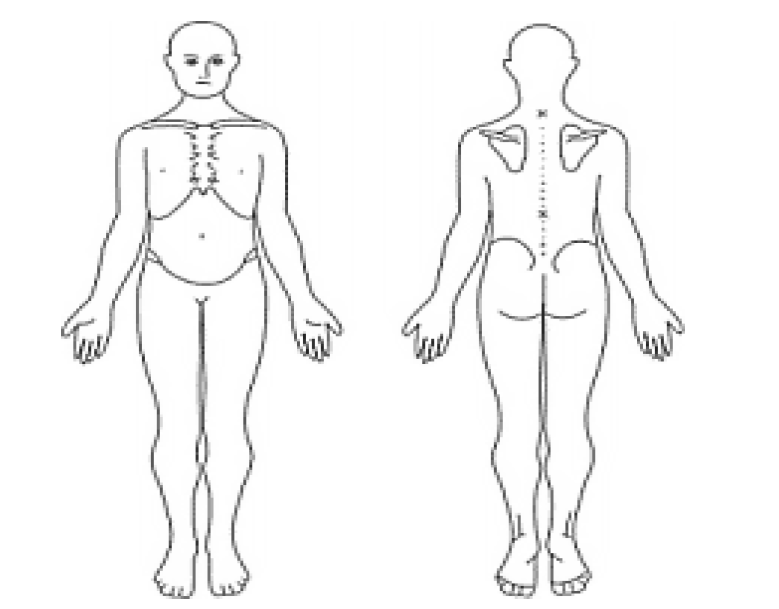
RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

**\*\* Benefits quoted are not a guarantee of payment and any balances not covered by the insurance carrier are the sole responsibility of the patient. \*\***

Circle which part(s) of your body that is bothering you then

mark that part of the body on a scale from 1-10 with 10 being

the worst pain ever.

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