Chart#:_____

MASSAGE THERAPY

Last Name: _____Legal First:_____Middle Initial:_____

Sex: ___M___F Birthdate:____/____/____ Single___ Married___ Widowed___ Divorced___ Separated___

Phone Number#:_____

Email:_____

Address:_____
street city state zip

Emergency Contact:_____Relationship:_____Phone#:_____

Reason for getting a massage?_____

_____

Please check areas you would like massaged:
___head ___face ___neck ___upper chest ___back ___glutes ___arms ___hands ___legs ___feet

Please check conditions you have had:
__Spinal Injuries
__Heart Attack
__Surgeries:_____
__Broken Bones (past 2 years):_____
__Other Accidents or Injuries (past 2 years):_____

Please check conditions you currently have:
__High Blood Pressure
__Low Blood Pressure
__Heart/Circulatory Issues
__Varicose Veins
__Seizures
__Kidney Issues
__Thyroid Issues
__Eczema/Psoriasis
__Contagious Infection(s)
__Diabetes
__Autoimmune Issues
__Endometriosis
__Fibroids
__Other medical condition(s):_____

Are you pregnant? ___No ___Yes, due date: _____

Patient Name: _____Chart#:_____

INFORMED CONSENT

I hereby request massage therapy services at Lubovich Chiropractic P.A. I understand, as with any health care procedures, that there are certain complications, which may arise during massage therapy treatments. I do not expect the therapist to be able to anticipate all risks and complications, and I wish to rely upon the therapist to exercise judgment during the course of the procedure(s) which the therapist feels at the time, based upon the facts then known, that are in my best interest. I have had an opportunity to discuss the nature, purpose and risks of massage therapy. I have had my questions answered to my satisfaction. I also understand that specific results are not guaranteed. If there is any dispute about my care, I agree to a resolution by binding arbitration according to the American Arbitration Association guidelines.

MY CERTIFICATION

This medical history given is accurate and complete to the best of my knowledge. I agree to keep the practitioner updated as to any changes in my medical profile because massage/bodywork should not be performed under certain medical conditions. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Additionally, appointments not kept or cancelled with less than 24 hour advance notice will be subject to a fee of the usual cost of the service. I understand that massage is not a replacement for medical or chiropractic treatment and that the therapist is not responsible for diagnosing any injury or other medical condition.

MY PRIVACY

I have had access to a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditations.

FINANCIAL RESPONSIBILITY

I understand and agree that I am expected to pay for massage services at the date and time of appointment. **I understand that failure to show for my scheduled appointment and same day cancellation will result in a cancellation/no-show fee. I understand massage gift certificates need to be present at the time of the appointment in order to be used. Lost certificates will not be reimbursed by Lubovich Chiropractic P.A.**

I hereby acknowledge and assume the potential risks associated with receiving treatment during the COVID-19 pandemic, including becoming infected with COVID-19 through this elective treatment, and give my express permission to you and the staff at your office to proceed with care.

Patient (or legal guardian)
Signature:_____Date:_____