Date: ____/____/____

MASSAGE

Mr O Mrs O Ms O Dr O Full name: _____

Address: _____ Suburb & Postcode: _____

Phone (H):_____ (M): _____ (W): _____

DOB: ____/____/____ Email: _____

Marital status M W S D Partners name: _____

In case of emergency please contact: _____ on: _____

Pregnant: Y/N Weeks: ___/40 Name/ages of children: _____

Occupation: _____ How did you hear about us? _____

Sports, hobbies or regular activities: _____

GP Name: _____ GP Address: _____

GP Phone: _____ Health fund: _____

Do you have any of the following? Please tick.

O Allergies: (Please specify) _____

O Cancer	O Chronic Pain	O Diabetes	O Epilepsy
O Headaches	O Heart condition	O Infectious conditions	O Joint replacement
O Kidney condition	O Osteoporosis	O Pregnancy	O Skin Disorders
O Surgery	O Varicose veins	O Whiplash	

O Any other concerns: _____

Are you on any regular or temporary medication at the moment? Please explain:_ _____

_____

Reason for massage therapy:

O Referred by GP / Chiropractor / Naturopath / Dietitian / Acupuncturist / Other: _____

O Pain relief	O Muscular injury	O Stress reduction	O Reduce Anxiety
O Wellness	O Relaxation	O Other: _____	

Are there any areas you would like your massage therapist to focus on? _____

_____

How long has this been a concern? _____

Have you had any other treatments for this? _____

Client consent:

I understand that the massage I receive at A.C.E. Wellness is provided with the intention of reducing pain, relieving muscle tension, improving circulation, increasing range of motion and enhancing relaxation.

If I experience any pain or muscle discomfort during the massage, I will immediately inform the therapist so that the pressure and/or strokes can be adjusted to my level of comfort.

Massage should not be construed as a substitute for a medical examination, diagnosis, or treatment. I understand that the Massage Therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness. Nothing said in the course of the consultation shall be construed as such.

I understand that massage should not be performed under certain medical conditions. I affirm that I have stated all my medical conditions and medications, and have answered all questions honestly. I agree to keep the Massage Therapist updated as to any changes to my medical profile, and I understand that there shall be no liability on the Massage Therapist, should I fail to do so.

I understand any illicit or sexually suggestive remarks or advances made by me will result in the termination of the consultation.

I understand the Massage Therapist has a right to refuse treatment on anyone deemed to have a condition for which massage is a contraindication.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date; I also understand that I need to give 24 hours notice if I need to reschedule any future massages, so that the appointments can be offered to the waiting list. A late cancellation fee of 50% of the consultation will apply if I do not give appropriate notice.

I acknowledge that I have read the consent to Massage Therapy and I understand that if at any time I have concerns, they can be discussed with my therapist.

I understand my personal information is confidential; however A.C.E. Wellness may need to correspond with various third parties, including GP's, Specialists or Insurance Companies.

I give permission for A.C.E. Wellness to release my information for this purpose only. I also give A.C.E. Wellness permission to take my photograph and use it on the front desk system for the sole purpose of client identification.

Client Signature: _____ Date: ____/____/____ CA Signature_____

A.C.E. Wellness provides a SMS service to remind you of your appointments. All clients are automatically enrolled in this service. If you do not wish to have this service, please indicate below:

O Please do not send me SMS reminders for my appointments.

PAYMENT OF ACCOUNTS

Thank you for choosing A.C.E. Wellness as your specialised wellness centre. We recommend that you read the following information concerning payment of your account. At A.C.E. Wellness, we pride ourselves on the relationships we have between ourselves and our clients.

The trust we have between our clients and ourselves is paramount in the provision of treatment for you. For this reason, we ask you to always provide us with the most up to date information concerning your address, contact details and status of your claim.

Liability for payment of your account for treatment always rests with you as the recipient of our services here at A.C.E. Wellness. This also includes the situation where the insurer or other organisation or body nominated by you declines to pay for any reason.

If you are pursuing a Workers Compensation, Motor Accident claim or other legal proceedings arising from the injuries for which we are treating and the relevant insurer has accepted liability for medical treatment, then you should inform us without delay and provide us with the relevant documents specifying the insurer and claim number. A.C.E. Wellness can then forward accounts directly to the insurer for payment.

If however the insurer declines to pay such medical payments, or ceases paying during treatment, then you are liable for payment. As a matter of course however, if you are proceeding with a claim you should forward these paid accounts to you solicitor so they can be included in your claim and reimbursed to you at the end of proceedings.

Regrettably A.C.E. Wellness can not continue to provide services to you for accounts remaining in arrears for longer than 28 days, after which time A.C.E. Wellness also reserves the right to claim interest at the rate of 10% per day.

The team at A.C.E. Wellness look forward to continuing to strive to provide you with the best services available. Should you at any time have any questions concerning our account practices, please don't hesitate to contact us.

The above statements are not meant to cause offence, but have to be included to comply with the legal requirements concerning the provision of billing information. Please note that the outstanding accounts will be reported to the National Debt Default Register. This will affect future credit applications.

I acknowledge that I have been informed of the Payment of Accounts procedures at A.C.E. Wellness and agree and comply with these.

Signed: _____ Date: ___/___/___ CA Signature: _____