

Insights For Life LLC.

Martha Reed PhD, Metaphysician, Holistic Life Counselor, Coach, Hypnotherapist

18589 N 59th Ave. Suite 108-109

Glendale, AZ 85308

(623) 249-5888

**CONFIDENTIAL PATIENT INFORMATION
PLEASE FILL IN ALL PORTIONS OF THIS FORM
PLEASE ASK IF YOU NEED HELP**

Name of Patient _____

Permanent Address _____

City _____ State _____ Zip _____

Temporary Address _____ What dates? _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Marital Status _____

Phone (Home) _____ (Cell) _____

e-mail

Work Phone _____

Employed by _____ Occupation _____

Name of spouse (or parent if minor) _____

Work Phone _____

Employed by _____ Occupation _____

Name of relative not living with you _____

Whom may we contact in case of emergency? _____

Phone _____

How did you hear about us Newspaper _____ Event (which) _____
Location/Sign _____ Internet _____ Other (list) _____

Referred by _____

CENTER POLICY REQUIRES PAYMENT AT TIME OF SERVICES

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible. Refunds will not be given on packages purchased if they are not fulfilled, and no refunds will be given for treatments deemed "unsuccessful".

I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. Further more, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed (i.e. minor surgery, etc.)

Patient Signature

Date

Parent/Guardian Signature

**Insights For Life LLC. Policy for:
Rescheduled / Cancelled Appointments
NSF Check Fees**

PLEASE BE AWARE:

Appointments:

The patient is ALWAYS responsible to call **24 hours prior to the scheduled appointment time** to reschedule or cancel. Failure to do so will result in a \$ 45.00 charge to the patient for the missed appointment.

NSF Checks:

NSF checks that are returned to us will automatically mean a charge to the patient account of \$25. The patient will be responsible to replace the amount of the check in addition to the \$25 Non-Sufficient Funds amount.

Payment for services:

The patient is ALWAYS responsible for payment of all charges incurred.

I certify that I have read and understand the above policies. I guarantee payment of all charges incurred made payable to Insights For Life LLC.

Signed: _____

Parent or Guardian (if minor): _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Insights For Life LLC. Notice of Privacy Practices.
(Attached)

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian,
personal representative, etc.)

Revisions (if any):

Client Intake Form – Therapeutic Massage

The following information will be used to help plan safe and effective massage sessions.
Please answer the questions to the best of your knowledge.

Date of Initial Visit _____

1. Have you had a professional massage before? Yes No
If yes, how often do you receive massage therapy? _____

2. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain _____

3. Do you have any allergies to oils, lotions, or ointments? Yes No
If yes, please explain _____

4. Do you have sensitive skin? Yes No

5. Are you wearing contact lenses () dentures () a hearing aid () ?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please describe _____

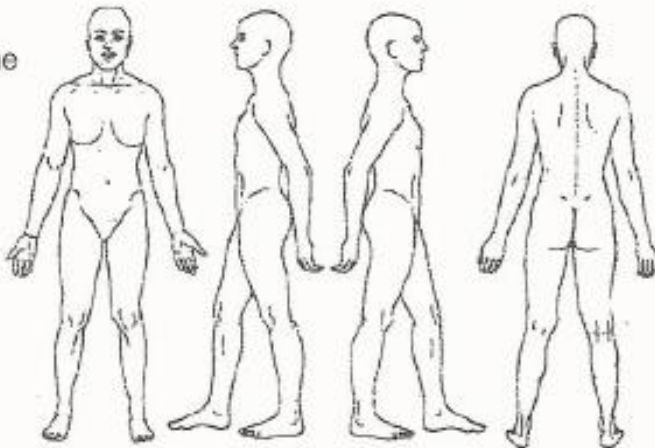
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No
If yes, how do you think it has affected your health?
muscle tension () anxiety () insomnia () irritability () other _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain
or other discomfort? Yes No
If yes, please identify _____

10. Do you have any particular goals in mind for this massage session? Yes No
If yes, please explain _____

Circle any specific areas you would like the
massage therapist to concentrate on
during the session:



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Medical History

In order to plan a massage session that is safe and effective,
I need some general information about your medical history.

11. Are you currently under medical supervision? Yes No

If yes, please explain _____

12. Do you see a chiropractor? Yes No If yes, how often? _____

13. Are you currently taking any medication? Yes No

If yes, please list _____

14. Please check any condition listed below that applies to you:

- | | |
|---|--|
| <input type="checkbox"/> contagious skin condition | <input type="checkbox"/> phlebitis |
| <input type="checkbox"/> open sores or wounds | <input type="checkbox"/> deep vein thrombosis/blood clots |
| <input type="checkbox"/> easy bruising | <input type="checkbox"/> joint disorder/rheumatoid arthritis/osteoarthritis/tendonitis |
| <input type="checkbox"/> recent accident or injury | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> recent fracture | <input type="checkbox"/> epilepsy |
| <input type="checkbox"/> recent surgery | <input type="checkbox"/> headaches/migraines |
| <input type="checkbox"/> artificial joint | <input type="checkbox"/> cancer |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> current fever | <input type="checkbox"/> decreased sensation |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> back/neck problems |
| <input type="checkbox"/> allergies/sensitivity | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> carpal tunnel syndrome |
| <input type="checkbox"/> circulatory disorder | <input type="checkbox"/> tennis elbow |
| <input type="checkbox"/> varicose veins | <input type="checkbox"/> pregnancy If yes, how many months? |
| <input type="checkbox"/> atherosclerosis | |

Please explain any condition that you have marked above _____

15. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

Draping will be used during the session – only the area being worked on will be uncovered.

Clients under the age of 17 must be accompanied by a parent or legal guardian during the entire session.

Informed written consent must be provided by parent or legal guardian for any client under the age of 17.

I, _____ (print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. In cases of suspected child abuse or dependent adult or elder abuse, for which we are required by law to report.
10. If a client is threatening serious bodily harm to another person(s), we must inform the intended victim.
11. If a client intends to harm himself or herself, we must act to protect the life of the client.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Insights for life LLC 18589 N 59th Ave. Suite 108-109, Glendale, AZ 85308. Note: *We must respond to this request within 30 days.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Insights for life LLC., 18589 N 59th Ave. Suite 108-109, Glendale, AZ 85308. You must provide us with a reason that supports your request for amendment.

Note: *We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Insights for life LLC., 18589 N 59th Ave. Suite 108-109, Glendale, AZ 85308. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at Insights For Life LLC.