CYNERGY
MASSAGE CLUB

Massage Therapy
Intake Form

Name: _____ Date: _____

Address: _____ City, State: _____

Zip Code: _____

Phone: _____ Other Phone: _____

Referred By: _____

E-mail: _____

Date of Birth: _____

Employer: _____

Have you had a professional massage before? Yes No (Please Circle One)

Please place an "X" next to the items below if you have been diagnosed with any of the following conditions:

___ HIV
___ Allergies
___ Arthritis
___ Asthma
___ Blood Pressure
___ Bone Disease
___ Broken Bone(s)
___ Bursitis
___ Cancer
___ Cysts / Lumps
___ Diabetes
___ Epilepsy
___ Headaches
___ Heart Problems
___ Hernia
___ Infection (current)
___ Infectious Hepatitis
___ Inflammation
___ Kidney Disease
___ Multiple Sclerosis
___ Numbness
___ Pregnancy ____ weeks
___ Sciatica
___ Skin prob. /rashes
___ Stroke
___ Surgery
___ Tennis Elbow
___ Varicose Veins

Emergency Contact Information:

Name: _____ Phone: _____

Relationship: _____ Alternate Phone: _____

Primary Complaint:

Please briefly describe the troublesome areas and what results you would like to receive from your massage session.

_____

_____

Please list any recent injuries and /or those that still cause discomfort:

_____

_____

Please list any current medications / supplements you are taking:

_____

_____

How often, and what kind of exercise program do you have for yourself?

_____

_____

Neurodivergences: (Check all that apply)

___ ADHD ___Autism Spectrum Disorder ___ Intellectual Disability ___ OCD

___ Sensitivities: _____

___ Other: (please list how we can support) _____

_____

_____

Mental Health Considerations: (Check all that apply)

___Anxiety ___ Depression

___Other:

CYNERGY
HEALTH & WELLNESS

MASSAGE THERAPY CONSENT

I understand that the massage I receive is provided for the basic purpose of relieving muscular tension, relieving pain, and facilitating range of motion and relaxation. If I experience any pain or discomfort during the 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. 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.

Massage should not be performed under certain medical conditions. As such, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the massage therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

I have read the above noted consent and I have had the opportunity to question the contents herein. By signing this form, I confirm my consent to treatment. I understand that at any time I may rescind my consent and massage therapy services will cease.

_____

Date

_____

Print Patient's Name

_____

Signature

CYNERGY
HEALTH & WELLNESS

Cancellation/Reschedule & Missed Appointment Policy for Massage & Acupuncture

Cancellation/Reschedule/Missed Appointment Policy:

Please be aware that we require 24 hours notice when cancelling, rescheduling or missing a Massage Therapy or Acupuncture appointment. For cancellations or rescheduling with less than the required 24 hour notice, regardless of the reason behind the need to move your appointment, an $94 full hour fee will be charged. We have implemented this policy as a courtesy to our acupuncturist and massage therapists. In the event that less than 24 hours notice was given, and we are able to fill the acupuncture or massage slot, the $94 fee will be waived; however, if we are *unable* to fill your vacated appointment time, we will charge the $94 fee for the cancelled appointment.

We will be retaining a Credit Card number stored in our secure system which will be used to charge the same day as the missed appointment. If you prefer to use a different card, please let our Front Desk know.

By signing below, I state that I understand and agree to the cancellation, reschedule / missed appointment policy upheld by Cynergy Chiropractic Center, Inc. for Massage and Acupuncture services.

_____
Print Name

_____
Signature

_____
Date

Credit Card # Required:_____ EXP_____

HIPAA: Consent for Purposes of Treatment, Payment, and Health Care Operations

I, _____, hereby consent to the use or disclosure of my protected health information by Cynergy Chiropractic Center, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Cynergy Chiropractic Center, Inc.

I understand that diagnosis or treatment of me by Cynergy Chiropractic Center, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Cynergy Chiropractic Center, Inc. is not required to agree to the restrictions that I may request. However, if Cynergy Chiropractic Center, Inc. agrees to a restriction that I request, the restriction is binding on Cynergy Chiropractic Center, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent Cynergy Chiropractic Center, Inc. has taken action in reliance on this consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created and received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Cynergy Chiropractic Center, Inc.'s Notice of Privacy Practices prior to signing this document.

Cynergy Chiropractic Center, Inc.'s Notice of Privacy Practices has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Cynergy Chiropractic Center, Inc.

The Notice of Privacy Practices also describes my rights and the duties of Cynergy Chiropractic Center, Inc. with respect to my protected health information.

Cynergy Chiropractic Center, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.

I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

_____
Date

_____