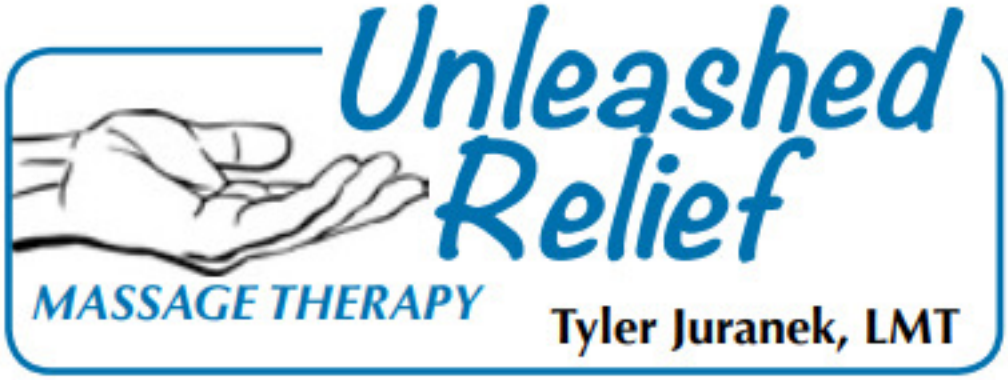

Unleashed Relief Client Intake Form

Please fill out this form by answering all health related questions to the best of your knowledge. Your answers will ensure a successful treatment at Unleashed Relief.

Personal Information

All fields marked with an asterisk are required.

Name*

Daytime Phone*

Evening Phone*

Address*

City*

State*

Zip*

Date of Birth*

Occupation (Optional)

Employer (Optional)

Email*

Primary Physician*

Emergency Contact Name*

Relationship to you*

Phone Number*

How did you hear about us?

Medical Information

Are you taking any medications?

Yes

No

If yes, please list name and use:

Are you currently pregnant?

Yes

No

If yes, how far along?

Any high risk factors?

Do you suffer from chronic pain?

Yes

No

If yes, please explain.

What makes your pain better?

What makes it worse?

Have you had any orthopedic injuries?

Yes

No

If yes, please list:

Please indicate any of the following that apply to you:

Cancer

Headaches/migraines

Arthritis

Diabetes

Joint Replacement(s)

High/low blood pressure

Neuropathy

Fibromyalgia

Stroke

Heart Attack

Kidney Dysfunction

Blood Clots

Numbness

Sprains or Strains

Explain any conditions you have marked above

Massage Information

Have you had a professional massage before?

Yes

No

What type of massage are you seeking?

Relaxation

Therapeutic/deep tissue

Other

If other, please explain in the box below.

What pressure do you prefer?

Light

Medium

Deep

Do you have any allergies or sensitivities?

Yes

No

If yes, please explain.

Are there any areas (feet, face, abdomen, etc.) you do not want massaged?

Yes

No

If yes, please list.

What are your goals for this treatment session?

Please list any areas of discomfort. (Please be specific)

By checking this box, I have completed this form to the best of my ability and knowledge, and agree to inform my therapist if any of the above information changes at any time.

I agree

Type Your Name

Date

Massage Client Information & Informed Consent Form

1. I understand that massage body workers and holistic practitioners are not medical doctors and do not diagnose illness, disease, or any physical or mental disorder. I acknowledge that massage and alternative holistic therapies are not substitutes for medical treatment, and that Unleashed Relief, “the company”, recommends I see a primary healthcare provider for service. I understand that is my responsibility to communicate with my therapist if I have concerns or questions about my session. I do not have any injuries or conditions that would prevent me from receiving a massage, nor have I been told by a health care provider that I should not receive massages or alternative therapies.
2. I understand that massage therapy and body work services are a therapeutic health aid and are non-sexual. I understand my massage therapist reserves the right to end a therapy session **in case of sexual innuendos or advances from the client.** I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the massage, and I will be liable for full payment of the scheduled session.
3. Any information exchanged during a massage or body work session is confidential and is only used to provide me with the best health care services available. I understand that a massage therapist will ask me questions about my health and physical condition and that I am obligated to answer truthfully and honestly about my health history in full detail.
4. I understand that my feedback is essential in my treatment, and that if I experience any unusual discomfort and/or pain during my massage session, it is my responsibility to inform the therapist in order to enable the therapist to adjust the pressure or technique being used.
5. The therapist reserves the right to decline, discontinue, or restrict services based on any provided information that may indicate that massage therapy would put my health or the therapist’s health at risk.

6. I acknowledge that I am responsible to be on time for my appointments and that the therapist is not under any obligation to extend my therapy session. I also agree that I am responsible to pay for the full time I have booked with the therapist if I am late. I understand that my appointment time is reserved for me only. If I miss an appointment or am unable to give twenty-four (24) hours' notice when I need to change or cancel my appointment, I agree to pay the company in full for the booked appointment time. I further understand that I will be additionally charged $35.00 for any returned checks.
7. I understand that massage therapy and body work are for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation and improvement of circulation and energy flow.
8. I understand that the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he perform any spinal manipulations.
9. I understand that service offered today, and in the future, are not a substitute for medical care and that any information provided to me by the therapist is purely for educational purposes and is not diagnostically prescriptive in nature.
10. I have stated all of my known medical conditions on the Client Intake form. I have consulted a medical doctor or licensed medical health care practitioner regarding any checked or described conditions.
11. I understand that it is solely my responsibility to keep the therapist updated on any changes in my physical health and I further understand that the company and the therapist shall not be liable for any purpose and for any reason whatsoever, should I fail to do the needful as per this paragraph.
12. I have reviewed this form in its entirety and I have discussed all my concerns regarding my treatment with my therapist.

ACKNOWLEDGEMENT

CLIENT:
By signing this "Informed Consent and Waiver", I consent to receive therapy at Unleashed Relief and hereby agree to all policies and release Unleashed Relief and massage therapist from any and all past, present, and future liability, loss, cost, claim, or damage whatsoever which may be imposed upon the Company relations to massage therapy.

By checking this box, I agree to and acknowledge the foregoing
I Agree*
Type Your Name*
Date*
Street Address*
City*
State*
Zip*
Phone Number*
Are You Under the age of 18?

Yes
No

PARENT/GUARDIAN WAIVER FOR MINORS:
If the client is less than 18 years old, the Client's parent and natural guardian hereby represents that he/she is, in fact, acting in that capacity, has consented to his/her child or ward's availing of the services of Unleashed Relief, and has agreed individually and on behalf of the child or ward, to the terms of this "Informed Consent and Waiver". The undersigned parent or guardian further agrees to save and hold harmless and indemnify Unleashed Relief from all liability, loss, cost, claim, or damage whatsoever which may be imposed upon Unleashed Relief relating to massage therapy and body work; including but not limited to reflexology, acupressure, polarity therapy, energy therapy, Reiki, nutritional therapies, all forms of kinesiology, aromatherapy, craniosacral therapy, myofascial release therapy, trigger point therapy, stretching and conditioning training, among others, on behalf of the Client and all of the Client's parents or legal guardians.

By checking this box, I agree to and acknowledge the foregoing
I Agree*
Parent or Guardian's Name*
Date*
Street Address*
City*
State*
Zip*
Phone Number*

Policy Notification

We appreciate that you've chosen us for your massage and bodywork needs. To provide the best service possible to our clients we have implemented the following policies.

Cancellation Policy
We respectfully ask that you provide us with a 24 hour notice of any scheduled changes or cancellations. We understand that certain circumstances may cause you to need to cancel or reschedule your appointment, but please give the very minimum notice of 3 hours. This allows us to offer that time to another client. Any appointments cancelled without at least a 3 hour notice are subject to $30.00 cancellation fee. Any missed appointments without notification will result in a charge for the full fee for the treatment missed which will be collected at the time of your next appointment. Your cooperation and consideration are appreciated.

Late Arrival Policy
We request that you arrive 5-10 minutes prior to your appointment time to allow time to fill out any required paperwork as well as answer any intake questions your therapist may have. WE understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so we can do our best to accommodate you. Appointment times are reserved for each client, so

oftentimes we cannot exceed that reserved time without making the next client late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time. Full service fees will be charged even when sessions are shortened due to late arrival. In return we will do our best to be on time, and if we are unable to do so we will add time to your session to make up for our late arrival or adjust the service charge accordingly.

Inappropriate Behavior Policy
Massage therapy is for relaxation and therapeutic purposes only. There is absolutely no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session. Depending on the behavior exhibited we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity and you will be treated the same in return.

By checking this box you agree to abide by these policies.
Type your name*

Financial Responsibility
I understand and agree that I am financially responsible for all services. I understand that all fees are payable at the time that services are rendered.

Cancellation Policy
I understand that I am asked to provide a minimum of a 3 hour notice if I need to cancel/reschedule my appointment , and that I may be charged a $30 fee if I do not give sufficient notice. I understand that I will be charged the full fee for treatment scheduled if I miss my appointment without giving notice.

Privacy Policy Acknowledgement
I acknowledge that Unleashed Relief, “Notice of Privacy Policy” has been provided to me. I understand I have a right to review Unleashed Relief’s Notice of Privacy Policy prior to signing this document. The notice of Privacy Policy describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills or in the performance of Unleashed Relief. The Notice of Privacy Policy for Unleashed Relief is provided upon request. This Notice of Privacy Policy also describes my rights and Unleashed Relief’s duties with respect to my protected health information. Unleashed Relief reserves the right to change the privacy practices that are described in the Notice of Privacy Policy. I may obtain a revised notice of privacy policy by requesting a copy be sent to me by amil or asking for one at the time of my next appointment.

By checking this box, I understand the above policies.

Type your name*

Notice of Privacy Policy

Effective Date: November 2022

This notice describes how personal health information about you may be used and disclosed, and how you can obtain access to this information.

We respect patient confidentiality and only release personal health information about you in accordance with State and Federal law. This notice describes policies related to the use of the records of your care generated by Unleashed Relief.

Personal and health information is collected in several ways

- Information we receive from you
- Information we receive from other healthcare providers.

During the course of our relationship, we will likely use and disclose health information about you for treatment, payment and healthcare operations. You may specifically authorize us to use Protected Health Information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosures will be made to any personal representatives you choose to have your protected health information.

Marketing

Unleashed Relief may use your health information for marketing communications, including birthday cards, newsletters, or appointment reminders by calls, text, emails, postcards, or letters. You may be sent information to support your health care, information about alternative treatments, and health-related services that may be of interest to you. Please know that if you do not wish to receive such communications, you must declare so in writing.

Disclosure

Your Protected Health Information may be disclosed without your consent or authorization, when required by law, as in the following instances:

- To a public health agency, for purpose such as controlling disease
- To the appropriate government authority in case of suspected child abuse or in other cases of suspected abuse, neglect, or domestic violence, information will be disclosed to the appropriate governmental authority, with your agreement or if required by law, if you are incapacitated, or if it appears necessary to prevent serious harm to you or others
- To health oversight authorities for regulatory, licensing, and other legal purposes
- In litigation, subject to certain requirements controlling the terms of the disclosure
- To law enforcement agencies, subject to applicable legal requirements and limitations

We may not disclose information about you for any other purpose without your written authorization, provided separately from your written consent.

Patient Rights

1. Upon written request you have the right to access, review or receive copies of your healthcare records. A reasonable fee may be charged for copies of your records.
2. Upon written request you have the right to receive a list of items this office has disclosed about your healthcare information.
3. You have the right to request this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information, the request must be in writing.
5. You have a right to receive all notices in writing.

If you have any questions, complaints or want more information, please contact Tyler Juranek, LMT at Unleashed Relief.

Complaints

Complaints, about your privacy rights or how your privacy is handled at this office, can be directed to Tyler Juranek, LMT by calling or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS (Office of Civil Rights), 200 Independence Avenue, S. W., Room 509F HHH Building,

Washington, D. C. 20201

I have read, reviewed, understand, and agree to the Notice of Privacy Policies for healthcare and/or other services provided through this office. This office has attempted to provide each patient with a Notice of Privacy Policies.

This copy is a copy for your review. Please ask if you would like to have a copy.