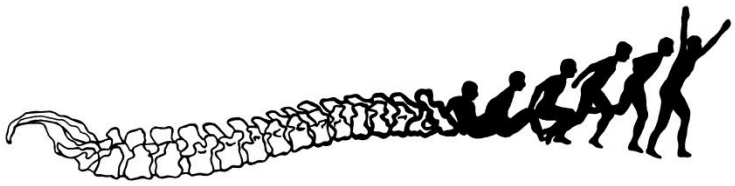


Lakeview Center Chiropractic, Acupuncture and Massage

10512 NE 68th St. C-102 Kirkland, WA 98033

Phone (425)889-4701 Fax (425)889-4702

Confidential Client Information & Health History for Massage

Name: _____ Date: _____

Date of Birth: _____ Phone #: Primary _____ Alternative _____

Email: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Health Information

In order to provide you with safe, appropriate, and client centered care, we need an accurate health history. Failure to disclose health information may increase the risk of significant injury and/ or long term negative effects to your health.

□ Cancer/ Tumors □ Blood Pressure (High, Low?) □ Immune System Deficiency

□ Diabetes (Type I, II?) □ Kidney/ Urinary □ HIV □ AIDs

□ Cardiovascular/ Heart Disease □ Osteoporosis □ PTSD, other stress related disorder

□ Heart Attack □ Osteoarthritis □ Fibromyalgia

□ Stroke □ Autoimmune Disease □ Chronic Fatigue Syndrome

□ Congestive Heart Failure □ Rheumatoid Arthritis □ Numbness/ Tingling

□ Blood Clots (DVT, Phlebitis) □ Breathing/ Respiratory □ Infectious Disease

□ Other/ Further explanation(s):_____ ___

_____

Allergies: _____

_____

Are you currently under the care of a Physician? □ Yes □ No

If yes, please indicate the condition(s) for which you are being treated: _____

_____

List all medications you are currently taking: _____

_____

List any supplements you are currently taking: _____

Have you had any surgeries? □ Yes □ No Please explain, indicate date(s):_____

Have you had any injuries or accidents? □ Yes □ No Please explain, indicate date(s):_____

_____

Are you Pregnant? □ Yes □ No If you are pregnant, please indicate which trimester and any associated conditions:

_____

General Questions

Have you ever had a therapeutic massage before □ Yes □ No

If yes, how often: _____

Primary reason(s) for massage therapy in the past: _____

Did massage therapy help reasons indicated? Please explain. _____

_____

What are your reasons/ goals today? _____

_____

I, hereby, acknowledge that all of the above information is correct. If I experience any changes to my health, I will let my health care practitioner know.

I understand that failure to disclose all health information and/ or provide updates regarding any changes to my health status may result in serious long term health consequences.

Printed Name: _____

Signature: _____

Date: _____

Massage Therapy Informed Consent

Massage therapy includes the assessment and treatment of soft tissue health (muscles, tendons, ligaments, fascia). Massage therapy does not include diagnosis of disease. Massage therapy is not a substitute for a medical examination. It is recommended that a person see a physician for any ailments they may be experiencing. There is no assurance or guarantee as to the results of treatment. As with any treatment, there can be risks.

By signing below, the patient agrees to the following:

- All patient records, including health history, treatment records, informed consent, or the like will be kept securely and confidentially for use by Lakeview Center Chiropractic, Acupuncture, and Massage.
- Written consent must be given by the patient prior to the release, or any sharing of my personal and clinical information with any 3rd party.
- A complete health history is required so that the massage therapist can formulate a treatment plan that is appropriate and safe for the patient. Nondisclosure of health conditions may put patient health at risk.
- Prior to treatment, the massage therapist will review the patient's records, and inquire about any health changes. After assessment and discussion of treatment plan, the massage therapist is required to receive verbal permission from the patient before treatment begins.
- If the patient becomes uncomfortable with the treatment, the patient may request a change or request an immediate stop to the session regardless of prior written permission.
- Draping will be used by the massage therapist as required only to uncover only those areas of the body that require treatment and/ or as the patient may choose to ensure their comfort level during treatment.
- As required by WA state law, additional signed informed consent must be given to undrape the chest or gluts.

  Chest: The chest will be covered by a drape at all times, except as treatment may require. In instances where treatment requires temporary removal of the main drape, a breast drape may be used to cover breast tissue. Verbal permission is required to work this or any other region of the body prior to beginning any session. The patient has the right to request a change or stop treatment at any time during treatment.

  By signing immediately below, the patient grants written permission for the massage therapist to modify the chest drape only for instances where it may be necessary. The patient may opt to change permission at any time. The patient maintains having read and understood the information above.
  Patient signature: _____ Date: _____

  Gluts: The gluts will always be covered by a drape except for specific treatment reasons. In those instances, the drape will be removed for the duration necessary for treatment and then recovered. Verbal permission is required to work this or any other region of the body prior to beginning any session. The patient has the right to request a change or stop treatment at any time during treatment.

  By signing immediately below, the patient grants written permission for the massage therapist to modify the glut drape for instances where it may be necessary. The patient may opt to change permission at any time. The patient maintains having read and understood the information above.
  Patient signature: _____ Date: _____

- The massage therapist may refuse to treat any patient or part of their body with just and reasonable cause. Common reasons include contagious illness, intoxication, health conditions where the law limits or prohibits treatment, or inappropriate behavior.

I, _____ (print name), have read the above noted consent and have had the opportunity to obtain clarity on any content I had questions or concerns about. I understand the information above and consent to receiving massage therapy treatment.

Patient signature: _____ Date: _____

Disclaimer:

This document and the information in it does not constitute legal advice. It is also not a substitute for legal or other professional advice. Users should consult their own legal counsel for advice regarding the application of the law and this document as it applies to the HIPPA regulations.

NOTICE: PATIENT PRIVACY Date: APRIL 1, 2003

We are committed to preserving the privacy of your personal health information. In fact, we are requires by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We are required by law to have your written consent before we use or disclose to others your medical information for purpose of providing or arranging for your healthcare, the payment for or reimbursement of the care that we provided to you, and related administrative activities supporting your treatment.

We may be required or permitted by certain law to use and disclose your medical information for other purposes without your consent or authorization.

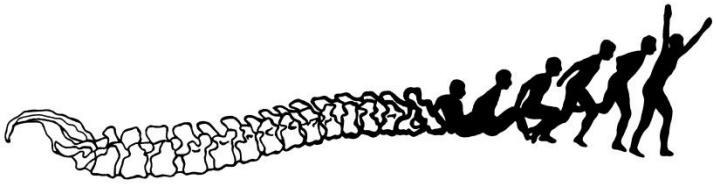
As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have the available a detailed Notice of Privacy Practices which fully explains your rights and our obligation under the law. We may revise our Notice from time to time. The effective date at the top right hand side of this page indicates the date of the most current Notice in effect.

If you have any questions, concerns or complaints about the Notice or your medical information please contact Dr. Daren J Penry at Lakeview Center Chiropractic.

_____ _____

NAME DATE



Lakeview Center Chiropractic Acupuncture & Massage
Office Policy

The following is an explanation of our clinic policies. We believe that clear definition will allow us both to concentrate on the most important issue: regaining and maintaining your health. We will be happy to answer any questions you may have regarding our policies, your account or insurance coverage.

No Charge Consultation for Chiropractic

Lakeview Center Chiropractic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problem. There is no charge or obligation in connection with this appointment.

Patient Payment Policy

We feel the patient's health needs are paramount; therefore our payment policy is an attempt to allow you, the patient, to receive the care you need and clear your balance with the least amount of difficulty.

New Patient Care Services

We require payment of the first visit charges on the same day of service. If we are billing your insurance then payment of your deductible and any applicable co-pay is expected on the first day of service. Properly documented worker's compensation and accident claims are not required to pay at this time if appropriate forms and leins are signed. However, if at any time your auto insurance denies payment - you are responsible for paying that amount. Payment will be expected within 30 days.

Established Patient Care Services

Patients under care are required to make regular payments, at the time of visit, or in advance, on all unpaid balances, except for properly documented worker's compensation or auto injury claims. However, if at any time your auto insurance denies payment - you are responsible paying that amount. Payment will be expected within 30 days. We may at our option charge on percent interest on all account balances over 30 days.

You will receive a monthly statement with all of your charges itemized. Please review these and retain for your records (taxes, etc.)

Our Policy on Health Insurance

Today most insurance policies do cover chiropractic/massage/acupuncture care. We will be happy to file your primary insurance claim for you and do anything we can to assure you receive proper reimbursement; however, we cannot take responsibility for what your health insurance will or will not cover.

Most insurance policies do cover chiropractic/massage/acupuncture care. However, if yours does not, we encourage you to urge your employer or health insurance broker to change your policy to one that does. Your freedom to choose your own health care provider is a fundamental right. If we can help in any way please let us know. Lakeview Center Chiropractic Acupuncture and Massage has patient payment options for those without health insurance.

It is important that you understand that health and accident insurance policies are an arrangement between an insurance carrier and you, the patient, their insured. Of course, Lakeview Center Chiropractic Acupuncture and Massage will prepare any necessary reports and forms to assist you in making collection from your insurance company. Furthermore, any amount authorized to be paid directly to Lakeview Center Chiropractic Acupuncture and Massage will be credited to your account on receipt.

However, you must clearly understand and agree that all services rendered to you are charged directly to you and that you are personally responsible for payment.

Appointments

It is important that you keep all of your agreed to and scheduled appointments. We ask that you call if you are unable to make your appointment or if you will be late. All missed appointments need to be made up as soon as possible in order to achieve positive response to care. Please help us to help others. We reserve the right to charge for missed appointments.

Emergency or After Hour Calls

In case of an emergency you may contact the office for a special appointment any time during regular office hours. If you, a friend or family member require after hours or weekend assistance, you may call the clinic for special assistance.

Questions And Answers

Your questions about any aspect of your care or account are invited. Please feel free to ask your doctor or any available staff member. We will make every effort to answer your inquiries.

I have read the Lakeview Center Chiropractic Acupuncture and Massage Policies and will honor them:

_____ _____

Patient's Signature Date

Coronavirus/ Covid-19 Informed Consent

The novel coronavirus (Covid-19) has been declared a Pandemic by the *World Health Organization* (WHO). The virus is considered extremely contagious and spreads through respiration and various other means.

To proceed with receiving care, I confirm and understand the following.

I understand that by consenting to receive massage therapy, the potential risk for exposure to Coronavirus (Covid-19) is a possibility. There are NO ACTIONS that can be taken to eliminate this risk. _____ ***Initials***

Personal Protective Equipment (PPE) may offer a moderate barrier against exposure. Using PPE does not eliminate risk. PPE includes surgical masks, n95/ 99 masks, face shields, goggles, gloves, etc

Cloth masks are not considered PPE by the *CDC*. As a barrier, they do not provide sufficient protection against incoming virus. However, a cloth mask may reduce the chance of the wearer from infecting someone else.

Proper handling of PPE and cloth masks is necessary to maximize their risk reduction potential. Improper handling of PPE and cloth masks may increase the chance of exposure to the wearer. _____ ***Initials***

Massage therapy requires close contact for a prolonged period of time, and as such, increases risk for both the therapist and patient as it is common to be infected and not know it.

Before symptoms occur, a person is contagious. Research shows that people are most contagious before onset of symptoms.

If symptoms do occur, it can take up to 14 days for them to develop.

Many infected persons never have symptoms. However, they are contagious. _____ ***Initials***

An infection can become serious and is sometimes fatal. Research suggests that Covid-19 may be 10x more fatal than the average strain of Flu (influenza).

Persons who are at high risk of severe complications and/ or death include those:

Over 60 years of age.

Have **ANY** underlying health problems. The top 5 include: Hypertension, Obesity, Chronic Metabolic Disease, Diabetes, & Chronic Lung Disease. _____ ***Initials***

Severe illness and complications have occurred in people that had no known health problems or risk factors.

While risk of severe illness increases with age, reports indicate that complications and death have occurred in younger people. _____ ***Initials***

If you feel sick, we ask you to cancel your appointment. _____ ***Initials***

A cancellation due to sickness will result in a delay of 14 days to reschedule OR you may bring written confirmation from a Physician which gives clearance to resume care. _____ ***Initials***

If you fail the temperature check-in or have respiratory and/ or other symptoms, we reserve the right to cancel your appointment. The appointment may be rescheduled for a future date at a minimum of 14 days OR you may get written confirmation from a Physician that gives clearance to resume care. _____ ***Initials***

I confirm that I am not experiencing any of the following symptoms: Loss of Smell or Taste, Fever, Dry Cough, Sore throat, Shortness of Breath, Runny Nose. _____ ***Initials***

Should you or someone you have had contact with gets an Covid-19 infection, we ask that you inform our office ASAP so we can take precautionary measures to help maximize the safety of staff and patients. _____ ***Initials***

Final Acknowledgment of Risk and Release of Liability

I, _____, have read, understand, and have initialed acknowledgment of the associated risks of receiving massage therapy as it pertains to the Novel Coronavirus (Covid-19). I have read, and understand, the methods being followed to help decrease everyone's risk as explained in the "*Coronavirus (Covid-19) Risk Reduction Procedures*" document. I asked about anything for which I did not understand or needed more clarification. I am satisfied with all answers given. I elect to receive care with this knowledge. I release Lakeview Center Chiropractic and its associates of all liability that may be associated with any future Covid-19 infection.

Signature:_____ Date:_____

*All information contained herein reflects the current knowledge and understanding of the Covid-19 event and PPE effectiveness. All reported information was gathered from verifiable sources, mainly from the *Centers for Disease Control and Prevention (CDC)* and *John Hopkins Bloomberg School of Public Health*. All information is current as of 5/10/2020.