ActiveLife Massage Therapy
2221 James St, Bellingham, WA 98225
(360) 306.0507

Welcome to ActiveLife Massage Therapy

Our purpose at ActiveLife is to establish open communication between you and your massage practitioner. Your comfort is vital and your healing is integral. Every step of the way we encourage any questions you may have as an educational tool toward a more ActiveLife. Please read the statements below and **initial to the left of each statement.**

_____I will inform the practitioner about my experience during and after the treatment session. This includes informing the massage practitioner if I experience pain or discomfort. **I am invited to request changes and state my needs.**

_____The treatment session can be tailored to my level of comfort with disrobing. If I have any reservations or concerns regarding disrobing, **I will inform the practitioner at the beginning of the session.**

_____It is not uncommon for soreness to occur post-session or for symptoms of a current or past injury to increase temporarily before resolving, specifically for deep tissue work. This may last for up to 48 hours post-session and may recur after the first three or four treatment sessions. To continue the treatment benefits and ease the soreness, I may be given supplemental instructions for home use (i.e. application of ice, heat, etc.). **I will contact the practitioner if I am not clear on the instructions or if I am unsure about any aspect of my post-treatment experience.**

_____Children under eight years of age who accompany me to an appointment will be required to accompany me into the treatment room.

_____Massage is not recommended when my immune system is fighting a cold or flu. **If I am experiencing these symptoms, I will cancel my appointment as far in advance as possible.**

_____If I need to cancel an appointment for a non-illness related reason, I will do so **at least 24 hours in advance**. Cancellations made fewer than 24 hours in advance are subject to a cancellation fee.

I understand that any associates of ActiveLife Massage Therapy cannot diagnose illness, disease, or other physical or mental disorders. Massage practitioners do not prescribe medical treatment or pharmaceuticals. Massage is not a substitution for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment I may have. Practitioners at ActiveLife may refer me to another licensed healthcare provider for diagnosis or treatment. I will state all my known medical conditions and take it upon myself to keep the massage practitioner updated on my health status. The practitioner may make notes on my intake form and I may request and review these notes. **I understand and agree to the information and policies stated above.**

Signature:____ Date: __________________

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Personal Contact Information

Full Name____ Date of Birth ______________

Street Address ______________________________ City/State/Zip ______________________

Phone___________ Alternate Phone _____________ E-mail __________________________

Occupation/Employer____

Primary Health Care Provider ____________________________________ Phone__________

Permission to consult with primary provider? Please Initial if Yes _____ No _____

Emergency Contact ______________________________________ Phone _______________

Insurance Company ______________________________________ Claim #_______________

ActiveLife sends an occasional e-mail newsletter. We respect your privacy and never share your e-mail with anyone. If you would like to **OPT OUT** and NOT receive these updates, please Initial Here _____

Health History and Treatment Information

Have you ever received a professional massage or other type of bodywork? No Yes

If you received massage previously, how often? ____________ Date of last massage __________

What results do you want from you massage sessions? _________________________________

____

How will you know that these changes have occurred?________________________________

____

Please circle the areas of your body that you give permission to receive massage:

Back Legs Buttocks Arms Abdomen Chest Neck Head Face Other____________

Are you currently seeing a medical practitioner? Please explain if yes:

Yes____ No

Are you currently seeing a psychotherapist or attending regular support group meetings? Please explain if yes: Yes____ No

List stress reduction and exercise activities. Include frequency___________________________

____

List current medications, including aspirin, ibuprofen, etc. ______________________________

____

Please circle allergies and list any additional: scents nuts perfumes other______________

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Health History

Please Check All That Apply

Musculo-Skeletal

__Bone or joint disease________________
__Arthritis________________
__Tendonitis________________
__Bursitis________________
__Head Injuries________________
__Neck, Shoulder, Arm Pain________________
__Sprains/Strains________________
__Low back, hip, leg pain________________
__Broken/fractured bones________________
__Jaw pain/TMJ disorder________________
__Headaches________________
__Spasms/Cramps________________
__Artificial Joints________________

Circulatory

__Heart Condition________________
__Varicose Veins________________
__Blood clots________________
__High blood pressure________________
__Low blood pressure________________
__Lymphedema________________
__Breathing difficulty________________
__Sinus problems________________
__Allergies________________
__Other________________

Infectious Disease

__Disease name________________

Skin

__Allergies________________
__Rashes________________
__Athlete's Foot________________
__Warts________________
__Easy bruising________________
__Other________________

Digestive

__Constipation________________
__Gas/Bloating________________
__Diverticulitis________________
__Irritable Bowel Syndrome________________
__Other________________

Nervous System

__Numbness/Tingling________________
__Chronic Pain________________
__Fatigue________________
__Sleep disorder________________
__Herpes/Shingles________________
__Other________________

Reproductive

__Pregnant? Stage________________
__PMS________________
__Other________________

Other

__Cancer/Tumors________________
__Diabetes________________
__Lupus________________
__Eating disorders________________
__Depression________________
__Drug/alcohol addiction________________
__Nicotine/caffeine addiction________________

Previous Health History: *Include Year and Treatment Received*

Surgeries____
____
____

Accidents____
____

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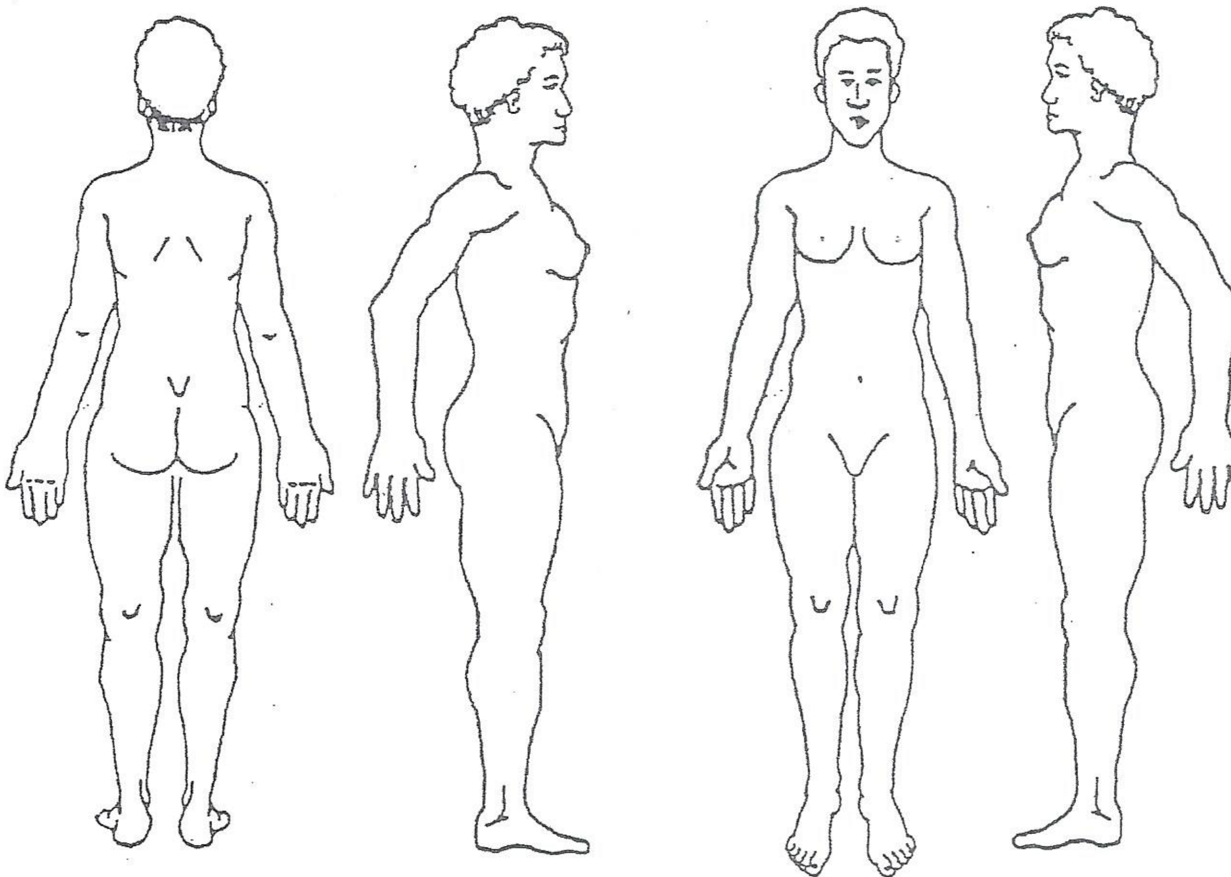
Personal Status Report

Name:____ Date:__________________

Please identify **CURRENT** symptomatic areas in your body by **DRAWING** the symbols and figures below.

Rate the **LEVEL** of pain/discomfort on a scale of **1-10**
with "1" representing no pain and "10" representing extreme pain.

Key:
- ○ Circle areas of PAIN and rate 1-10
- X "X" over areas of JOINT and MUSCLE STIFFNESS
- ⌇ Draw squiggly lines along th areas of NUMBNESS OR TINGLING
- ╫ Mark SCARS, BRUISES, or OPEN WOUNDS



Additional Comments:____

____

____

____

Personal Status Report

Name____ Date:__________________

Identify CURRENT symptomatic areas in your body by drawing the symbols on the figures below.

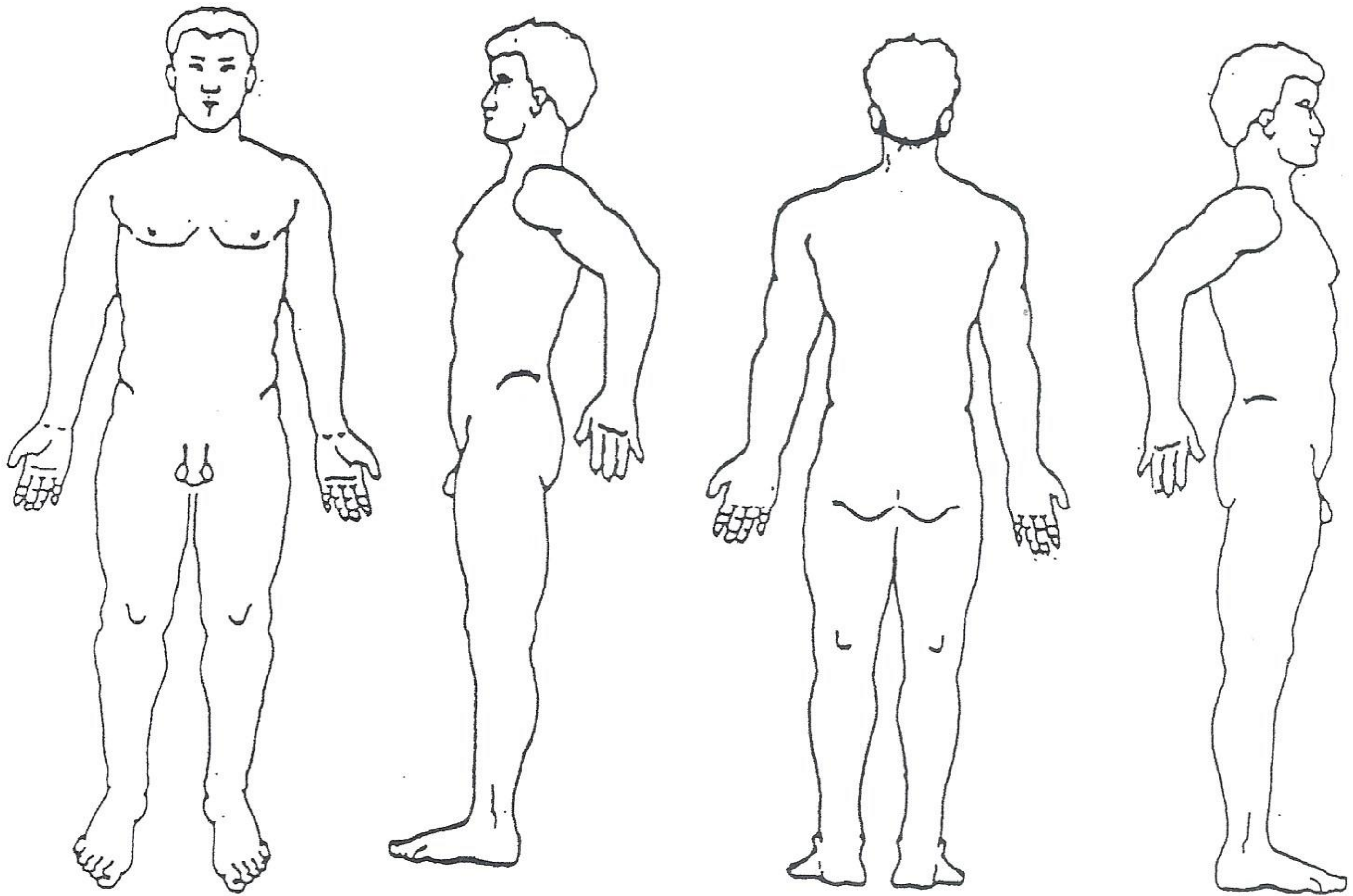
KEY:

○ Circle areas of PAIN

X "X" over areas of JOINT AND MUSCLE STIFFNESS

⌇⌇ Draw a squiggly lines along the areas of NUMBNESS OR TINGLING

𝍸 Mark SCARS, BRUISES, OR OPEN WOUNDS



Additional Comments:____

____

____

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Acknowledgement of Receipt of
Notice of Privacy Practices

- You may refuse to sign this acknowledgment

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____

Please PRINT Name

______________________________ ______________________________

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (please circle):

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify) ______________________________

____

____

NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice is effective 5/1/2011, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating the practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In in the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up all forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may use or disclose your health information to appropriate authorities if we reasonable believe that you are a possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.83 for each page, and $19.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to request a list of disclosures of your health information. This list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative mean or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handles under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer:
Jeff Counts LMP HIPAA Officer
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