Practitioner/Clinic Name: _____

Contact Information: _____

Screening Questionnaire

Client Information

Client Name: _____ Date: _____

Preferred phone number: _____ Best time to call: _____

Email address:_____ Preferred form of communication: _____

Massage Information

How did you hear about me? (referral, Facebook, etc.) _____

Is this a gift certificate? Yes ☐ No ☐

Massage history:

Have you had a massage/bodywork before? Yes ☐ No ☐

Frequency: _____

Types of massage/bodywork received: _____

Preferred types of massage: _____

Reasons for seeking massage? (relaxation, injury, etc.)

_____

Description of injury/health condition:

_____

Possible complications/medications:

_____

Expected outcomes (functional improvement, symptom relief, wellness):

_____

Typical activities of daily living (affected by condition?):

_____

Occupation (affected by condition?):

_____

Are you seeking insurance reimbursement? Yes ☐ No ☐

Car collision/personal injury? _____

On-the-job injury? _____

Private health insurance? _____

Do you have a physician referral with diagnosis codes? _____

Let clients know if you provide billing services, and if so, for what types of claims, or if you will simply provide receipts and/or copies of records for them to submit for reimbursement. Let clients know a physician referral demonstrating medical necessity is required for insurance reimbursement/health savings account reimbursement regardless of who submits bills.

Best times for massage: _____

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Practitioner/Clinic Name: _____

Contact Information: _____

Screening Questionnaire

Communication Checklist

Fees/forms of payment	Cancellation/No-show policy
Late arrival policy	Confidentiality
Parking/directions	Work setting
Clothing/shiatsu	Modesty/Nonsexual/draping
Food/drugs/alcohol	Oils/lotions/allergies

COVID-19 Related Questions

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you now, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ☐ No ☐
3. Do you now, or have you recently had, any chills, muscle aches, new loss of taste or smell, or new rashes or lesions? Yes ☐ No ☐
4. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

Inform clients of any new protocols you've implemented as a result of COVID-19, including directions about arrival, wearing a mask during the session, and getting set up for contactless payment beforehand.

Do you have special needs I should prepare for:

_____

Do you have any questions or concerns:

_____

If out-call, ask for directions, parking, or special instructions:

_____

Packet Checklist

- Health Information
- Health Status Report
- Billing Information
- Directions/map

Date sent _____

Additional Notes

_____

_____

_____

_____

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COVID-19 Health Information & Informed Consent

Client Name: _____

Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐

2. Do you now, or have you recently had, any respiratory or flu symptoms (including fever, chills, sore throat, cough, muscle aches, or shortness of breath)? Yes ☐ No ☐

3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐

4. Have you traveled anywhere outside of the state in the last two weeks? Yes ☐ No ☐

Location: _____

5. Have you had a new loss of sense of taste or smell? Yes ☐ No ☐

The following questions are specific to a new aspect of COVID-19 involving blood coagulation.

6. Can you exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

7. Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐

8. Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

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Consent for Treatment

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

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Practitioner/Clinic Name: _____

Contact Information: _____

Office Policies

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation

Amid the ongoing uncertainty of COVID-19, we have modified our cancellation policy to offer greater flexibility to all our clients. We hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule for whatever reason, and especially if you are not feeling well, we understand and request for you to please contact us as soon as possible to reschedule. To further support you, there will be no penalties for cancellations at this time.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illness. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. If it is within the 24-hour notice period, the cancellation fee may be waived.

If this office is providing billing services, please be advised of our billing policies.

Cancellation

We do not bill insurance companies for missed appointments or late cancellations. You are responsible for paying the missed appointment/late cancellation fees.

Financial Responsibility

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance, deductibles, and co-pays. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits

Your signature below authorizes and directs payment of medical benefits to the massage/bodywork practitioner for services provided by this office.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: _____ Date: _____

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