Health Intake

Please do not wear any scented products

Name: **Date of birth:**

Address:

City/State/Zip:

Employer: **Occupation:**

Email: **Cell phone:**

Referred by:

Please circle one: **Married** **Single** **Other**

Accidents, Surgeries, and Illnesses:

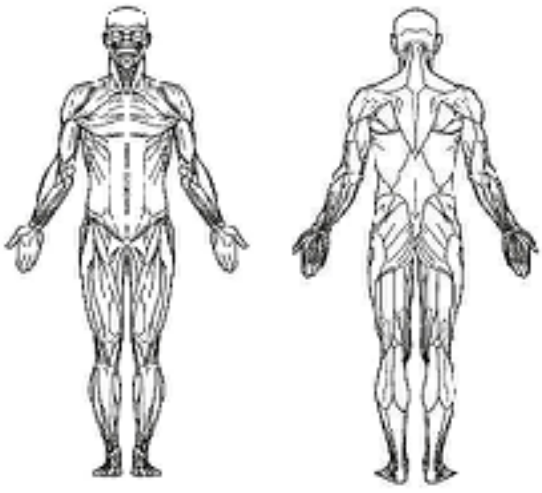
Please list any medical conditions or allergies I should be aware of:

Are you on any medication you put on your skin topically?

Your Symptoms

Please rate your symptoms on a scale of 1 (low) to 10 (high)_____.

Please mark your symptoms on the chart below.



Signature:_____**Date:**_____

Release/Informed Consent

Release: I authorize the release of any medical records or other information necessary to process this claim. I authorize payment of medical benefits for massage therapy.

Informed Consent: The information I gave is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform my practitioner of any pain during the session. I understand that bruising can occur with deep tissue work depending on my hydration, nutrition, and other factors. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment. I agree to update the massage practitioner with any changes in my health and understand that there shall be no liability on the practitioner's part should I forget to do so.

Insurance: I understand that it is my responsibility to know my insurance coverage, and any quote is not a guarantee of payment. I will be responsible for the balance should my insurance not pay. Co-Payments are due at the time of service unless prior arrangements have been made. RX is required for all treatments billed to insurance. Accounts six months past due will be turned over to collections.

Signature: _____ **Date:** _____

Hipaa Compliance

I, _____, hereby consent and state my preference to have my provider, Alisha Morgan, LMT / Zen Body Health communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing. I consent to my name and phone number being stored on the provider's personal phone.

I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party.

You may text stop to 425.686.9988 at any time to end this authorization. This will opt you out of all communication including appointment reminders.

Signature: _____ **Date:** _____