

CLIENT INFORMATION (Please print)

Please note: The following information will not be shared with anyone without your written permission, except where legally necessary.

Name: _____ Hm Tel. # () _____ Cell tel. # () _____

Work Tel. # () _____ E-mail address: _____

Address: _____ City: _____ State: _____ Zip: _____

In case of emergency: _____ Tel. # () _____

How did you hear about this office: Internet _____ / Telephone Book, Fairpoint YP _____ or Talking

Phone Book _____ / Other source _____ . **OR**

Referred by: _____ Tel. # () _____

Occupation: _____ Age: _____ Date of Birth _____ male female

Physician: _____ Phone # () _____

Yes No Have you ever experienced a professional massage or bodywork session??

How recently? _____

General medical information:

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible on the "Comments" lines. Continue onto the back if necessary.

Yes No Do you frequently suffer from stress?

Yes No Do you have diabetes?

Yes No Do you experience frequent headaches?

Yes No Are you pregnant?

Yes No Do you suffer from arthritis?

Yes No Are you wearing contact lenses?

Yes No Are you wearing dentures/braces?

Yes No Do you have high blood pressure?

Yes No If Yes to previous, are you taking medication for this?

Yes No Do you suffer from epilepsy or seizures?

Yes No Do you suffer from joint swelling?

Yes No Do you have varicose veins?

Yes No Do you have any contagious disease?

Yes No Do you have osteoporosis?

Yes No Do you have allergies?

Yes No Do you bruise easily?

Yes No Have you had any broken bones in the past 2 yrs?

Yes No Have you been in an accident or suffered any injuries in the past two years?

Yes No Have you had any surgeries? Explain below.

Yes No Do you have cardiac or circulatory problems?

Yes No Do you suffer from back pain?

Yes No Do you have numbness or stabbing pain anywhere?

Yes No Do you have tension or soreness in a specific area? Please specify. _____

Yes No Are you sensitive to touch or pressure in any area?

Yes No Do you take any medications?

Comments: _____

I have read, understand, and signed the attached HIPPA

Disclosure: Yes _____ No _____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage/bodywork should not be performed under certain conditions; I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment.

Client's signature: _____ Date: _____

Consent to treatment of Minor: By my signature below, I hereby authorize Kathleen L. Young to administer massage, bodywork or somatic therapy techniques to my child or dependent as she may deem necessary. I understand that it is necessary for me to be in the room with the practitioner while she is performing this work.

Signature of parent or guardian: _____ Date: _____

**Kathy Young Therapeutic Massage& Hypnosis
HIPPA - Notice of Privacy Practices:**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information:

Please review it carefully; the privacy of your health information is important to me.

My Legal Duty

I am required by applicable federal and state law to maintain the privacy of your health information. I am also required to give you this Notice about my privacy practices, my legal duties and your rights concerning your health information. I must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until I replace it.

I reserve the right to change my privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. I reserve the right to make the changes my privacy practices and the new terms of my Notice effective for all health information that I maintain, including health information I created or received before I made the changes. Before I make a significant change in my privacy practice, I will change this Notice and make the new Notice available upon request.

You may request a copy of your Notice at any time. For more information about my privacy practices, or for additional copies of this Notice, please contact me using the information listed at the end of this Notice.

Uses and Disclosures of Health Information:

I use and disclose health information about you for treatment and healthcare operations.
For example:

Treatment: I may use or disclose your health information to a physician or other healthcare provider, providing treatment to you. I will do this only as law permits and/or only with your written approval.

In addition: you may give me written authorization to use your health information or to disclose it to anyone for any purpose. If you give me written 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 me a written authorization, I cannot use or disclose your health information for any reason except as described in this Notice.

To Your Family and Friends: I must disclose your health information to you, as described in Client Rights section of this Notice. I may disclose your health information to a family member, friend or other person to the extent necessary to help you're your healthcare, but only if you agree that I may do so in writing.

Persons Involved in Care: I 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, I will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, I will disclose health information based on a determination using my professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

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

Required by Law: I may use or disclose your health information when I am required to do so by law.

Abuse or neglect: I may disclose your health information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. I 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: I may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. I may disclose to authorized federal officials health information required for

lawful intelligence, counterintelligence, and other national security activities. I may disclose to correctional institution or law enforcement official having lawful custody of protected health information or inmate or client under certain circumstances.

Appointment reminders: I may use or disclose your health information to provide you with appointment reminders, such as voice mail messages, post cards or letters.

Client Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that I provide copies in a format other than photocopies. I will use the format you request unless I 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. I will charge you a reasonable cost-based fee for expenses such as copies or time. You may also request access by sending me a letter to the address at the end of this Notice. If you request copies, I will charge you \$ 3.00 per page and \$30.00 per hour for the time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, I will charge a cost-based fee for providing your health information in that format. If you prefer, I will prepare a summary or an explanation of your health information for a fee. Contact me using the information listed at the end of this Notice for a full explanation or my fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which I disclosed your health information. If you request this accounting more than once in a 12 month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

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

Alternative Communications: You have the right to request that I communicate with you about your health information by alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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

Electronic Notice: If you receive the Notice on my Web site or by electronic mail (email), you are entitled to receive this Notice in written form.

Questions and Complaints:

If you want more information about my privacy practices or have questions or concerns, please contact me.

If you are concerned that I may have violated your privacy rights, or you disagree with a decision I 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 me communicate with you by alternative means or a alternative locations, you may complain to me 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. I will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

I support your right to privacy of your health information. I 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.

Kathy Young, LMT, CH, NCTMB 603-623-9900
46 Holly Street, Manchester, NH 03102 Kathy@KathyYoungMassage.com

I have read and understand the above information:

Date: _____

Full legal signature