



## Policies and Procedures

Welcome to Edmonds Massage Center! The following is an explanation of our office policies and procedures. We believe that a clear understanding will allow us both to concentrate on the most important issue: regaining and maintaining your health. We are happy to answer any questions that you may have and grateful to be at your service.

The procedure time for your treatment is 45-60 minutes. When you schedule, one full hour is set aside specifically to meet your needs. We do not double book appointments and are unable to place another client in your space without sufficient prior notice. Therefore when you are scheduled, it is imperative that you make your appointment and that you arrive on time.

Our time is valuable too. Cancellation notice is required **24** hours prior to your treatment time. **24** hours allows us to make your time slot available to another client in need of treatment. If notice is not given, there will be a \$40.00 charge to your account. We are unable to bill your insurance for cancellation fees. It is solely your responsibility. **THE FEE MUST BE PAID PRIOR TO YOUR NEXT APPOINTMENT.**

Our billed massage therapy fees for Injury Treatment Massage are \$27.50-\$35.00 per unit (4 units=1 hour). If the massage session is paid in full at the time of service, "time of service discount" will apply. Under no other circumstances will this fee be adjusted. I understand and agree that the policies and procedures are an arrangement between carrier and client. Insurance will be certified and billed as a courtesy to you; however, the client understands that he or she is responsible for treatment not covered by the insurance. In the event that your insurance denies payment, you the client become responsible for payment in full. A 1% interest per month will be charged on balances over 60 days.

It is my choice to receive massage therapy. I realize and understand that massage therapists do not diagnose or prescribe. I agree to communicate with my practitioner regarding any changes in my insurance plan or circumstances. I further agree to communicate with my practitioner any time I feel my well-being is being compromised.

**MY SIGNATURE INDICATES THAT I HAVE READ, UNDERSTAND AND AGREE TO THE POLICIES STATED ABOVE.**

CLIENT SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**EDMONDS MASSAGE CENTER**  
**CONFIDENTIAL HEALTH INTAKE FORM**

NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Please answer the following questions by circling yes or no and provide any necessary clarifications.

- YES NO Have you ever had a professional massage?  
YES NO Do you exercise regularly or participate in any sports? What kind and how often?  
\_\_\_\_\_  
YES NO Are you currently under the care of any other health care provider for a specific condition?  
YES NO Do you take any vitamins, minerals, or medication (including aspirin or ibuprofen) Please list medication, dosage, and condition \_\_\_\_\_  
\_\_\_\_\_  
YES NO Have you ever had surgery? Please list date(s) and procedure(s) \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have or have you ever had cancer? What type and when? \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have or have you ever had heart problems? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have high or low blood pressure? Please circle one.  
YES NO Do you have varicose veins, blood clots or any other circulatory conditions not mentioned? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have diabetes? How is it controlled? \_\_\_\_\_  
YES NO Do you have arthritis? Osteoarthritis or Rheumatoid? (please circle one) Where is it located? \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have bone or joint problems? Please describe: \_\_\_\_\_  
YES NO Do you experience prolonged episodes of depression or other emotions?  
YES NO Do you have any infections or contagious diseases? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Are you experiencing any sleep disorders or changes in normal sleeping patterns? Please explain: \_\_\_\_\_  
\_\_\_\_\_  
YES NO Are you pregnant? What stage? \_\_\_\_\_  
YES NO Do you wear contacts, dentures, or hearing aids? \_\_\_\_\_  
YES NO Do you have any other medical conditions your therapist should be aware of before you receive massage? \_\_\_\_\_  
\_\_\_\_\_  
YES NO Do you have any needs that require special attention? Please explain: \_\_\_\_\_  
\_\_\_\_\_

**Please read carefully, sign, and date.**

I understand that massage therapists do not diagnosis illness, disease or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals. It has been made clear to me that massage is not a substitute for medical examination or diagnosis and that is recommended that I see a physician for any ailment I may have. I have stated all my known medical conditions and I am responsible to inform my massage therapist of any changes in my physical or mental health. I understand that my massage therapist is an independent contractor at Edmonds Massage Center, LLC. I indemnify and hold harmless Edmonds Massage Center, LLC from any loss or liability arising from services provided by my massage therapist.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

EDMONDS MASSAGE CENTER PATIENT REGISTRATION FORM

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ M.I. \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

CELL# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ HOME# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ WORK# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

DRIVERS LICENSE # \_\_\_\_\_

EMAIL: \_\_\_\_\_

PLEASE CIRCLE ONE: SINGLE - MARRIED - DIVORCED - WIDOWED - OTHER

EMPLOYED? FULL TIME / PART TIME STUDENT? PART TIME / FULL TIME

SCHOOL / EMPLOYER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

HOW WERE YOU REFERRED TO EMC? \_\_\_\_\_

WOULD YOU LIKE US TO VERIFY YOUR MASSAGE THERPAY BENEFITS?

PRIMARY INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SUBSCRIBER EMPLOYER: \_\_\_\_\_

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX) \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER

\*SECONDARY INSURANCE: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SUBSCRIBER EMPLOYER: \_\_\_\_\_

INSURANCE ID # (PLEASE INCLUDE LETTER PREFIX) \_\_\_\_\_

RELATIONSHIP TO SUBSCRIBER: (PLEASE CIRCLE) SELF, SPOUSE, CHILD, OTHER