Massage Policies and Procedures

Patient Agreement: It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical or chiropractic care, medical or chiropractic examination or diagnosis. I have stated all medical / chiropractic conditions that I am aware of and will inform my practitioner of any changes in my health status.

CANCELLATION POLICY – We respectfully ask that you provide us with a 24 hour notice of any schedule changes or cancellation requests. Please understand that when you cancel or miss your appointment without providing a 24 hour notice, we are often unable to fill that appointment time. This is an inconvenience to your therapist and also means our other clients miss the chance to receive services they need. For this reason, you will be charged a $95 cancellation fee. We require a credit card number to be given to charge cancellation fees as needed.

CREDIT CARD #____EXP DATE________CV CODE_____ZIP________

We understand that emergencies can arise and illnesses do occur at inappropriate times. If you have a fever, known infection, or have experienced vomiting or diarrhea within 24 hours prior to your appointment time, we request that you cancel your appointment. Inclement weather may also result in the need for late cancellations. We will do our best to give advanced notice if we are closing or need to cancel due to bad weather, and we ask you to do the same. Please do not risk your own safety trying to make your appointment. Late cancellation due to emergency, illness, or inclement weather will generally not result in any missed session charges, but this is determined on a case by case basis by the office director.

LATE ARRIVAL POLICY – We request that you arrive 10-15 minutes early to your appointment time to fill out required paperwork as well as answer any intake questions your massage therapist may have. We understand that issues can arise that may cause you to be late for your appointment. However, we ask that you call to inform us if this ever occurs so that we can do our best to accommodate you. Specific appointment times are reserved for each client, so often times we cannot exceed that reserved time without making the next client late. For this reason, arriving after your appointment time may result in loss of time from your massage so that your session ends at the scheduled time. Full service fees will be charged even when sessions are shortened due to late arrival. In return, we will do our best to be on time, and if we are unable to do so, we will add time to your session to make up for our late arrival or adjust the service charge accordingly. Patients who are chiropractic and massage: we coordinate our chiropractic and massage schedules very precisely. Dr. Warwick will know if / when you are getting a massage, and as long as you are on time for both appointments, you will receive the full treatment needed and scheduled from Dr. Warwick and also our massage therapists.

INAPPROPRIATE BEHAVIOR POLICY – Massage therapy is for therapeutic and relaxation purposes only. There is absolutely no sexual component to massage whatsoever. Any insinuation, joke, gesture, conversation, or request otherwise will result in immediate termination of your massage session and a refusal of any and all services in the future. You will be charged the full service fee regardless of the length of your session. Depending on the behavior exhibited, we may also file a report with the local authorities if necessary. Treat your therapist with respect and dignity, and you will be treated the same in return.

ASSIGNMENT OF BENEFITS – I am responsible for all charges for all service provided. In the event that my insurance company denies payment, or makes a partial payment, I am responsible for any balance due. I authorize and direct payment of insurance benefits to Warwick Chiropractic for services billed by any massage therapists employed by Warwick Chiropractic.

RELEASE OF RECORDS – I authorize the release of records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information to my attorneys, healthcare providers, and insurance companies for the purposes of processing my claims.

GRATUITIES — Gratuities are never expected in a therapeutic massage setting but are always at our patient's discretion. Gratuities must be paid directly to the massage therapist through cash or check.

To help us ensure clarity of communication, **please initial the following**:

___ I acknowledge and understand Warwick Chiropractic's Massage Policies and Procedures.

I, ____________________________________(print name) understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage 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 therapists are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand there shall be no liability on the therapist's part should I fail to do so.

Name of Patient: ______________________________ Date:____________________

Signature:__________________________________ Case: AUTO / WORK INJURY / SELF PAY

Parent Signature if Patient is a Minor: ____________________ Date:____________________

WARWICK CHIROPRACTIC & MASSAGE

_______________ Today's Date

For Our Licensed Massage Therapist

Title:_______ First:_______________________ MI:___ Last:_______________________________

Address: ❒ I'm a chiropractic patient, and my address, cell phone, and email are on file.

❒ I'm not a chiropractic patient, and my address is: _______________________________

City, State, Zip:_______________________________________Cell phone: _______________________

Email:______________________________DOB:________________ Referred by: ___________________

Have you had a professional massage before? ❒ No ❒ Yes—how often? _______________________

Do you have any difficulty lying on your front, back, or side? ❒ No ❒ Yes (describe):__________________

Do you have any allergies to oil, lotions, or ointments? ❒ No ❒ Yes (describe):___________________

Do you have sensitive skin? ❒ No ❒ Yes (describe):_____________________________________

Are you wearing: ❒ Contact lenses ❒ Dentures ❒ Hearing aid ❒ None

Do you sit for long hours at a workstation, computer, or driving? ❒ No ❒ Yes

Do you perform any repetitive movement in your work, sports, or hobby? ❒ No ❒ Yes

Do you experience stress in your work, family, or other aspect of your life? ❒ No ❒ Yes

If yes—how has it affected your health? ❒ Muscle tension ❒ Anxiety ❒ Insomnia ❒ Irritability

❒ Other (describe):____

Is there a particular area of your body where you often experience tension, stiffness, pain, or other discomfort?

❒ No ❒ Yes: ____

Do you have any particular goals in mind for your massage session? ❒ No ❒ Yes (describe):__________

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Are you currently under medical supervision? ❒ No ❒ Yes:______________________________

Have you had a recent accident or injury? ❒ No ❒ Yes:________________________________

Have you had a recent fracture? ❒ No ❒ Yes:____

Have you had a recent surgery? ❒ No ❒ Yes:____

WOMEN ONLY: To your knowledge are you pregnant? ❒ No ❒ Yes—Due date:_________________

Please mark whether you NOW HAVE (❍) or had IN THE PAST (❒) any of the following conditions/illnesses:

❍ ❒ Open sores or wounds
❍ ❒ High blood pressure
❍ ❒ Diabetes
❍ ❒ Easy bruising
❍ ❒ Artificial joint
❍ ❒ Sprains/strains
❍ ❒ Current fever
❍ ❒ Swollen glands
❍ ❒ Circulatory disorder

❍ ❒ Asthma/respiratory issues
❍ ❒ Varicose veins
❍ ❒ Atherosclerosis
❍ ❒ Phlebitis
❍ ❒ Blood clots
❍ ❒ Joint disorder
❍ ❒ Tendonitis
❍ ❒ Osteoporosis
❍ ❒ Epilepsy

❍ ❒ Cancer
❍ ❒ Decreased sensation
❍ ❒ Back/neck problems
❍ ❒ Carpal tunnel syndrome
❍ ❒ Tennis elbow
❍ ❒ Surgical hardware
❍ ❒ Currently taking painkillers
❍ ❒ __________________
❍ ❒ **No Conditions / Illnesses**