Client Intake and Informed Consent Form

Name: ____ Date: _____________________

Address: ____

City: _______________________________________ State: _________ Zip: _____________

Daytime Phone #: _____________________________ Evening Phone #: ___________________

Email Address: ________________________________

Date of Birth: ______________________________ Sex: ________________________________

Occupation: ___________________ Employer or School: ________________________________

Have you had a professional massage before? ❑ No ❑ Yes (if yes, how long ago?) ______________

In Case of Emergency, Please Notify:

Name: ____ Telephone #: __________________

Relationship: ____

I, _____________________________, (client) understand that massage therapy provided by Jonathan Drummey (massage therapist) is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation, improve body awareness, increase sense of well-being, and offer a positive experience of touch. Any other intended purposes for massage therapy are specified below:

The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Health Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not part of massage therapy.

I have informed the massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes.

____ _________________________________
Client (or Guardian) Signature Date

(please continue to other side if we will be billing insurance)

Insurance Information

Primary Health Care Provider: ____

Telephone #: ____ Extension: __________________

Permission to Consult with Primary Provider? ❑ No ❑ Yes ____________________ (please initial if yes)

Referring Health Care Provider (if different from above): ______________________________________

Telephone #: ____ Extension: __________________

Permission to Consult with Referring Provider? ❑ No ❑ Yes ___________________ (please initial if yes)

Insurance Carrier: _______________________________ Telephone #: ______________________

Name of Insurance Plan/Program: ____

Insurance ID: ______________________ Group ID: _______________________________________

Co-pay Amount (if applicable): ___________________

Name of Insured (if you are carried on someone else's policy): _ ________________________________

Address (if different): ____

City: ____ State: _________ Zip: ______________

Daytime Phone #: ______________________________ Evening Phone #: _____________________

Email Address: ________________________________ Relationship to you: ___________________

Date of Birth: _________________________________ Sex: _________________________________

Occupation: ______________________ Employer or School: ________________________________

Please check each box to indicate you have read and agree to the following statements and sign below:

- ❑ I authorize Jonathan Drummey to give my insurance company any and all information necessary for consideration of insurance claims for the above named client.
- ❑ I authorize Jonathan Drummey to be paid directly for services billed on insurance claims for the above named client.

____ __________________________________

Client (or Guardian) Signature Date