The Wellness Center MN Massage Intake Form

First Name_____ **Middle Initial**_____ **Last Name**_____

Pronouns_____ **E-mail**_____ **Birthdate**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ □ Home □ Cell □ Other

E-mail Appointment Confirmation Opt-in □ Yes □ No **Text Appointment Confirmation** Opt-in □ Yes □ No

Email Newsletter & Membership updates Opt-in □ Yes □ No

How did you hear about us? _____ **Name** _____

Is this your first professional massage? □ Yes □ No

What is your pressure preference: _____

What results would you like to achieve?_____

Please note any areas of your body that you prefer NOT to be massaged/touched: _____

Do you have any of the following today? □ sunburn □ inflammation □ severe pain □ headache □ blisters

□ open cuts, bruises, burns □ irritated skin rash □ poison ivy □ cold/flu □ COVID-19 symptoms

Exercise □ None □ Moderate □ Daily □ Heavy Describe_____

Occupation_____ Work Activity □ Sitting □ Standing □ Light Labor □ Heavy Labor

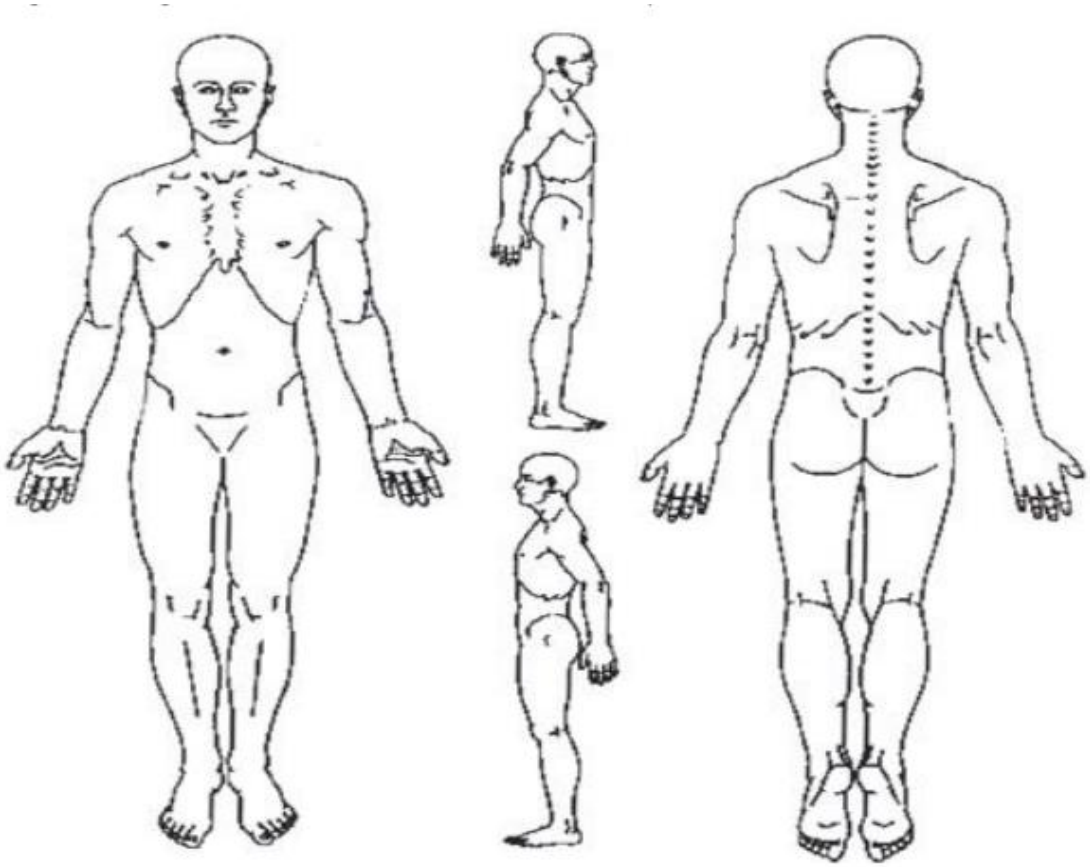
Are you pregnant? □ Yes □ No Due Date: _____ Allergies_____

Medications like blood thinners or other related medications_____

Do you have any health conditions? Please list any relevant medical conditions, surgeries, accidents, and bone, joint or muscle diseases or injuries. Include date of diagnosis or incident.

_____

Please indicate with an "X" or Circle the places you are feeling discomfort



Authorization

I certify that the above information is correct to the best of my knowledge. I will not hold the massage therapist or any members of his/her/their staff responsible for any errors or omission that I may have made in the completion of this form. I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status. I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during a massage session is educational in nature and is to be used at my own discretion. I understand that therapeutic massage is the only type of massage offered and no late-night appointments are available at The Wellness Center MN.

Age Verification Policy

The Wellness Center MN does not provide massage therapy or float therapy services to anyone under 18 unless that person has written consent from their parent or guardian, or the therapy has been prescribed by their physician or health care provider. You will be required to provide The Wellness Center MN with a valid government-issued identification (with a photo) that proves that you are 18 years or age or over.

Payment/Cancellation Policy

I acknowledge that payment is due at the time of service. The Wellness Center MN accepts auto injury insurance under a separate agreement. Please provide a medical prescription and insurance information for consideration for this billing service. Cancellations must be received 24 hours in advance of appointment time. I acknowledge responsibility for paying full rate for any appointment cancellation of less than 24 hours. Exceptions may be made for illness or emergencies.

Notice of Privacy

I acknowledge that The Wellness Center MN, by way of this document, has informed me that they follow Minnesota's Privacy Practices and the Freedom of Access Act, Chapter No. 460-House File 3839; not that I have read it or agree with its contents.

Signature _____ Date _____

Auto or Work Injury Cases for Insurance

Claim #_____

Policy/Group #_____

Name of Primary Insured, if other than Patient_____

Social Security #_____

Insurance Company Name_____

Insurance Company Address_____

Insurance Contact Agent_____

Contact Agent Phone #_____

Date of Accident_____

Referring Physician_____

Physician's Phone #_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to People-Centered Therapies, LLC DBA The Wellness Center MN all insurance benefits, if any, otherwise payable to me for services rendered. I acknowledge that cash rates do not apply towards insurance billed services. I understand that I am financially responsible for all charges including collection costs and attorney fees, whether or not paid by insurance. I agree to notify People-Centered Therapies, LLC DBA The Wellness Center MN of any communication about my insurance benefits or independent medical exam. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party_____

Relationship_____ Date_____