Jarrod Morrow LMT, CAMT OBM # 10335

Name: _____ Date:_____

Street: _____City: _____

ZIP:_____

Phone:_____Cell:_____

Email: _____Date of Birth:_____

Insurance Company(if using]: _____ Member ID:_____

How do you feel today? Any pain? If yes please explain feeling and severity.

Are you currently seeing a Physician? Please explain any current health problems.

Please list any surgeries, major illnesses, or injuries in the last 5 years.

What would you like out of your massage today?

Please circle all areas you give permission to receive massage:

ALL head neck back shoulders chest arms hands hips legs feet

Informed Consent for Massage Therapy

I understand that massage therapy provided by Jarrod Morrow LMT is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch.

The general benefits of massage, possible massage contra indications 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 Caregiver 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 an intended 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. I understand that there shall be no liability on the practitioner's part due to my forgetting to relay any pertinent information.

If I experience any pain or discomfort during the session, I immediately communicate that to the therapist so the treatment can be adjusted.

HIPPA Compliance

By signing this you authorize Jarrod Morrow LMT to share medical information about you for the purpose of payment for services rendered to insurance companies and/or other health care organizations, as consistent with the Health Information Privacy and Accountability Act's guidelines for proper use of protected information.

Statement of Financial Responsibility

I understand that the massage therapist is billing my insurance on my behalf for all services rendered. However, if for any reason insurance does not cover my cost for massage therapy care I am responsible for payment of those services rendered.

_____

Signature

_____

Date