Avalon
HOLISTIC THERAPIES

Intake

CLIENT NAME_____ **DATE** _____
Please Print Clearly

CLIENT INFORMATION

Address_____

City _____State_____ Zip_____

Occupation _____Date of Birth _____

Phone (Home) _____ (Cell) _____ Ok to Text? ☐ Yes ☐ No

E-mail Address _____ (For use by Avalon Holistic Therapies, LLC only)

Emergency Contact _____ Phone _____

How did you hear about Avalon? _____ Ok to use your name when thanking? ☐ Yes ☐ No

GENERAL HEALTH INFORMATION

What are your typical daily activities – work, home, exercise?_____

_____

What substances are you currently taking? (prescribed medications, over the counter medications, herbs, supplements, alcohol, recreational drugs) _____

Are you currently under a physicians care?_____ What for? _____

What do you currently do to relieve stress? _____

_____

Have you ever received massage before? _____ When? _____

Why? What was the outcome?_____

What are your current goals for massage? _____

CURRENT SYMPTOMS

Are you currently experiencing any of the following? (If yes, please explain and list any medications taken within last 24 hrs)

Pain/tenderness ☐ No ☐ Yes: _____

Numbness or tingling ☐ No ☐ Yes: _____

Allergies ☐ No ☐ Yes:_____

Stiffness ☐ No ☐ Yes: _____

Swelling ☐ No ☐ Yes: _____

Location and type: Draw circles on the figures below to indicate the location and size of your current symptoms.

P = pain or tenderness

S = joint or muscle stiffness

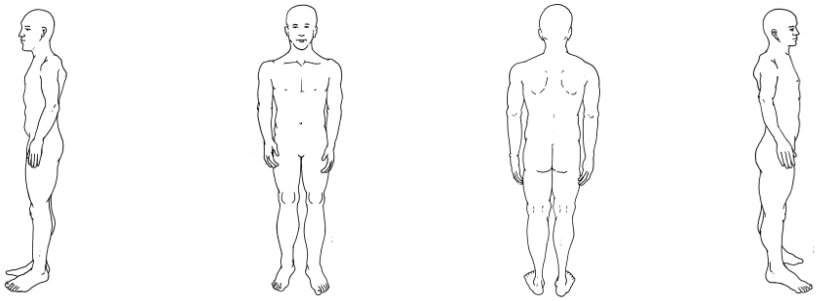
N = numbness or tingling

Comments:

_____

_____

_____



Intensity: Circle the number on the scale to indicate your current levels of **pain** and **activity restriction**.

No Pain	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Extreme Pain**
No Restriction	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**All activity restricted**

Over

HEALTH HISTORY Please provide information **for the past 5 years**, including type, approximate dates and treatment

Surgeries _____

_____

Major Illnesses _____

_____

Injuries _____

_____

HEALTH CONDITIONS Please circle any **current** and **previous** conditions

General			**Comments**
Pain	Numbness	Altered Sensation	_____
Headaches	Fatigue	Sleep Disturbances	_____
Infections	Swelling	Allergies	_____
Skin Conditions			
Abrasions/Cuts	Rashes	Other	_____
Muscles and Joints			
Arthritis	Osteoporosis	Scoliosis	_____
Fractures	Sprains	Strains	_____
Bursitis	Tendonitis	Stiffness	_____
Disk Problems	TMJ	Other	_____
Cardiovascular and Respiratory			
Anemia	Angina	Arteriosclerosis	_____
Congestive Heart	Failure	Heart Attack	_____
Heart Disease	Hypertension	Irregular Heart Beat	_____
Varicose Veins	Blood Clots	Phlebitis	_____
Asthma		Other	_____
Nervous System			
Concussion	Head Injury	Stroke	_____
Anxiety	Depression	Other	_____
Endocrine System			
Diabetes	Thyroid	Other	_____
Digestion and Elimination			
Heartburn	Gastric Reflux	Ulcers	_____
Bowel Problems	Gas/Bloating		_____
Urinary Tract Problems		Other	_____
Reproductive System			
Pregnancy	PMS	Other	_____
Cancer or Tumors			
Benign	Malignant		_____

CONSENT TO TREATMENT

I verify that all of the information provided is correct and current to the best of my knowledge. I understand that I will receive a therapeutic massage for the purpose of maintaining good health and physical condition. I hereby give my consent to receive therapeutic massage from Avalon Holistic Therapies, LLC.

Signature_____ **Date** _____

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Client Policies & Procedures

As part of your wellness team:

- We will provide **competent and professional service** to you by staying educated and up to date through publications and/or continuing education classes. If your needs extend beyond our scope of practice, we will assist you in finding a qualified practitioner to help you continue working toward your goals.
- We will treat you with **respect and integrity** as we strive to achieve your wellness goals together. Your modesty will be respected through proper draping of all body parts not being worked on.
- We will show up **mentally, emotionally and physically prepared to focus on your needs** that day. If we need to cancel, we will do so with at least 24 hours' notice. If less time is required due to unavoidable circumstances, a $20 credit will be offered on your next session.
- We will return your calls within 24 hours unless it is a scheduled vacation time or holiday.
- We strive to offer **excellent service** with **reasonable rates**. If a client is dissatisfied with their service and no other arrangements can be agreed upon, a 50% discount will be honored.
- We will **respect your privacy** by keeping your personal information and session details confidential.

As our client, you agree that:

- **_____ (Initials) You will arrive at your session sober, clean and in a timely fashion.** If you are late to your session, it will end on time with full payment due. If your session extends over your scheduled time (with your agreement) you will not be charged extra. ****Sessions include intake and exit interviews. ****
- **_____ (Initials) You will be prepared to pay for your session at the time of service**. (Unless your Insurance is being billed. If your insurance denies the bill, **YOU ARE STILL RESPONSIBLE FOR THE BILL**.) **Checks and cash** are preferred but we also accept Visa, MasterCard, Amex and Discover. If your check bounces, you agree to pay any and all fees incurred. If your check bounces again, you agree to be placed on a cash basis thereafter.
- **_____ (Initials) You will give 24-48 hours notice if you can't keep your appointment. If you cancel with less than 24 hours or fail to show up, the FULL time of service session price is still due and a bill will be sent to your home address. If you are paying with insurance, this amount is not billable and is due directly from you.** Sufficient notice is required so that we can help someone else in your stead. Thank you for being respectful of our time as we are respectful of yours.
- **_____(Initials) You desire to take an active part in your healing and wellness goals by letting us know if something needs to change or stop.** This is your session. If you experience pain or discomfort, LET US KNOW.
- **If it is decided you need to see another practitioner, we will assist you in whatever manner we can.** This is your journey and your choices will be honored. Thank you for allowing us to share it with you.

Medical Massage Therapy Services: $35 per unit

Time of Service Discount: 30 Min - $40 1 hour - $75 1½ hours - $105 2 hours - $135

Signature:_____ **Date:**_____

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Release of Information

I, _____ give permission to Avalon Holistic Therapies to release my Personal Health Information to and communicate with:

(Example: MD, ND, DC, Insurance Company, Family Member, Care Providers, etc.)

_____

_____

_____

_____

_____

Concerning my treatment and sessions from:

_____ to _____
(Date) (Date)

_____ _____
(Signature) (Date)

1675 SW Marlow Ave., Suite 315, Portland, OR 97225
www.AvalonHolistic.net
(503) 544-2463

Avalon
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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by us (Avalon Holistic Therapies, LLC – Including your LMT or our office staff) for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the business and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Your protected health information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example: Obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of massage students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to students that see clients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your practitioner. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your practitioner, or the practitioner's practice, has taken an action in reliance to the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected Health information: Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your practitioner is not required to agree to a restriction that you may request. If a practitioner believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information: We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **November 3, 2015.** It remains in effect until we replace it.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

_____ _____

Signature Date

_____

Print Name