Master's Touch

CLIENT INFORMATION

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Maine License MT6060
207/595-8328

NAME_____ Date of Birth_____

ADDRESS:_____ Occupation_____

CITY/STATE/ZIP:_____

PHONE: (primary)_____ (other)_____

EMAIL:_____ REFERRED BY:_____

Emergency Contact:_____ Phone:_____

Reason for pt:_____

Areas of complaint:_____

PLEASE ANSWER ALL QUESTIONS

Have you ever had a professional massage?.....YES NO
Are currently under physician care?.....YES NO

Exercise regularly or participate in sports?.....Yes NO *if yes how often?_____

Please check & explain any of the following recent/current conditions

__Illness with Fever	__Heart Disease	__Allergies	__Take Medications
__Pain (specify next page)	__Stroke	__Blood Clots	__Recent Surgery (specify next page)
__Low/High Blood Pressure	__Arthritis/Gout	__Phlebitis	__Acute Injury
__Rheumatoid Disorder	__Bone/Joint disease	__Lupus	__Dizziness
__Asthma/Emphysema	__Spinal Problems	__TMJ	__Headaches
__Crohn's/Irritable Bowel	__Vericose Veins	__Diabetes	__Cardiac Pacemaker
__Numbness/Tingling	__Lymphedema	__Cancer	__Alcohol/Tobacco use
__Infectious Conditions	__Skin Problems	__MS	__Other
__Osteoporosis/Osteopenia	__Limited Motion	__Pregnant	

***if any of above conditions apply please elaborate attached page**
***any medical information not included above please note on attached page**

PATIENT ACKNOWLEDGEMENT

Massage and bodywork therapy practices are designed to promote and maintain the health and well-being of the client, but do not diagnose illness, disease, impairment or disability. If I experience any pain or discomfort during this session, I will immediately inform the therapist. As massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all my known medical conditions and will keep the therapist updated as to any changes in my medical condition.

SIGNATURE:_____ DATE:_____

When/how did the symptoms begin? _____

What aggravates/alleviates your symptoms? _____

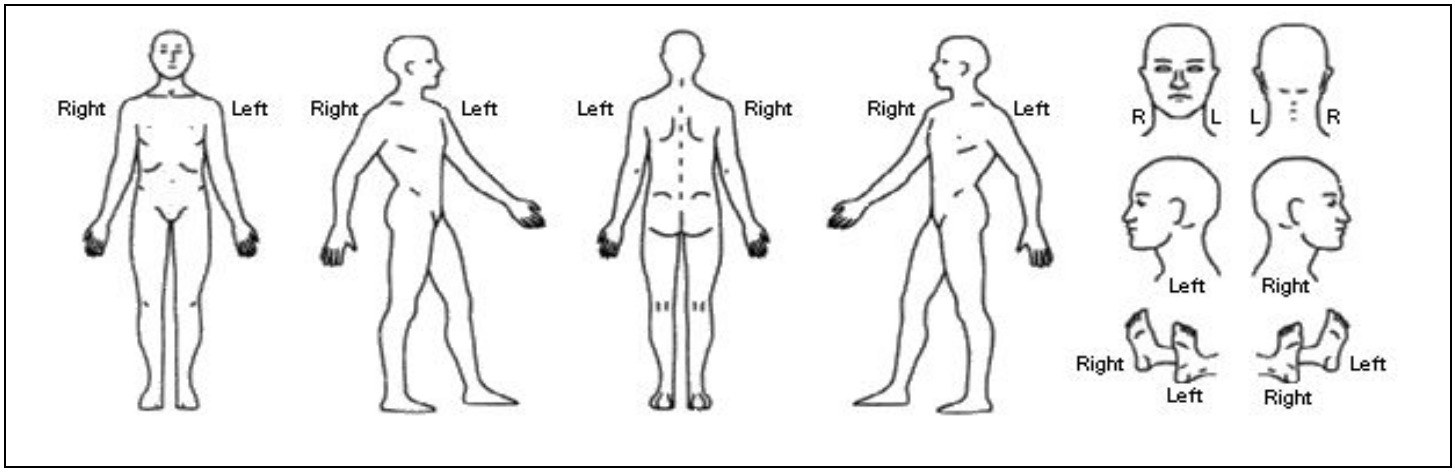
What are your treatment goals? _____

Physicians/providers that you've treated or consulted with about your current symptoms.

List tests performed in the past 12 months due to your symptoms (e.g. xray, CT, MRI, lab, bone scan, arthrogram) as well as the date and result.

List all surgeries. _____

On the diagrams below, please circle the location of your pain or symptoms. Then, next to each circled area, write the number that reflects your current pain level using the numeric pain scale below.



Communication

You benefit the most from our relationship when you ask questions or candidly tell me about your symptoms, progress, or concerns. Whether paper or electronic, your files will be stored in a safe and secure manner. To communicate efficiently, I may email, text, or call based on your preferences. These technologies may not be secure. By signing below, you waive any objection to communication between us via your preferred method.

Your Treatment

Please wear clothing that facilitates maximum movement and treatment. Our sessions are typically 60 minutes, although longer and shorter sessions are available. Plan to arrive 5-10 minutes prior to each session time. You

may cancel your session by giving 24 hours notice**.** Please note that cancellations without 24 hr notice or no show appointments will be charged in full due to the limited space of available appointments. I understand that emergencies happen and these situations will be taken into consideration for last minute cancellations. Prior to rescheduling payment for cancellation or no show will be required. Thank you for your cooperation to this policy.

Insurance

Master's Touch, LLC, does not participate with insurance companies and therefore is an out-of-network, non-participating provider. However, except for Medicare, you may be reimbursed by your insurance company depending on your plan. Please contact your insurance company for information about how to submit a claim.

You may also submit proof of payment for reimbursement under your HSA or FSA. If you have primary or secondary Medicare coverage, you cannot submit claims for reimbursement. Because *Master's Touch, LLC* does not participate with Medicare, services related only to general wellness, prevention, fitness, or massage can be provided. Thus, under Medicare guidelines, you must accept full financial responsibility for all services provided and agree to not submit any claims to Medicare.

Payment

Payment is due in full at each session or in advance for discounted packages. Cash or check is accepted as payment.

Master's Touch, LLC
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Bridgton, ME 04009
207.595.8328

4MastersTouchLLC@gmail.com

Master's Touch, LLC

Privacy Statement Signature Page

Master's Touch, LLC, protects your privacy and only uses your confidential health information for services or treatment; reporting, collaborating, or communicating with your physician(s) or other treatment provider(s); administrative activities; or payment. Your personal health information may be disclosed without prior authorization in an emergency or when required by law. In all other situations, your written authorization or consent will be obtained before your personal health information is disclosed. If you give written authorization, you may later revoke that authorization at any time or for any reason. You have a right to obtain a copy of your personal health information at any time or request that inaccurate or incomplete information be corrected.

I read, understand, and voluntarily agree to these Treatment Guidelines. I voluntarily consent to care and treatment by *Master's Touch, LLC*, as recommended or as prescribed by my physician or provider. I was given the opportunity to ask questions and receive information about my treatment, including the purpose, benefits, risks, and alternatives to treatment. Although treatment is usually beneficial, I acknowledge that no guarantees or promises about results or outcomes have been made to me because treatment is not an exact science. I understand my right to continue asking questions, stop treatment, or receive information about risks or alternatives to treatment. I accept the responsibility for candidly communicating about my health, medications, allergies, symptoms, treatment, or progress. I give permission to *Master's Touch, LLC*, to use or release my personal health information for services or treatment; reporting, collaborating, or communicating with my physician(s) or other treatment provider(s); administrative activities; or payment. I understand that I am responsible to pay for my treatment, and I have information about service fees.

Patient / Parent Signature: _____

Print Name: _____ Date: _____

Master's Touch, LLC

COVID UPDATE/INFO PAGE

In the wake of COVID-19, in accordance with State, Federal, OSHA and CDC guidelines and recommendations, Policies and Procedures are in place to help ensure everyone's health and safety.

I will be following the guidance of the scientific community, regulatory agencies, and my professional associations to operate as safely as possible, and greatly appreciate your respect and cooperation in helping me do so. Current protocol is carefully implemented to help protect all clients and staff, so I wanted to fill you in so you are prepared. Please review this information carefully PRIOR to your first appointment, so you know what to expect. You will be asked to initialize your understanding and agreement on the COVID-19 Supplemental Informed Consent Form and a copy will be kept in your chart. If you are uncomfortable with any of these procedures, I ask that you reschedule your appointment. If you would like additional information on the protocols in place — what I am doing to keep everyone safe I would be happy to share that information with you.

PRIOR TO YOUR APPOINTMENT:

•I will communicate with you beforehand to obtain any updates to your health information and ask you specifically about your potential exposure to COVID-19 (See COVID-19 Health Questionnaire, and please save a copy for your records).

ON THE DAY OF YOUR APPOINTMENT:

•Arrive at least 5-10 minutes before your scheduled appointment time, if possible with all necessary signed paperwork, if you've not already emailed it back.

•Text when you arrive and then wait in your vehicle. This helps ensure physical distancing between other facility clients and helps to guide/limit the locations we need to clean and sanitize.

•I will text back to let you know when I'm ready and then I will meet you at the front door.

•You should have already completed the COVID Health Questionnaire via text, email, or verbally over the phone prior to your scheduled appointment.

•IMPORTANT REMINDER: If you are sick with anything (including symptoms that could be explained as allergies or a cold) 14 days or less before your appointment, please call and cancel for your own safety, as well as ours and everyone else who is in the space. You will not be charged for a cancellation, even if it's last minute. The only way this works is if we're all honest with each other. Understand that if there is an exposure in our space, I will be required to close for up to 14 days. Needless to say, if I have to do that frequently, it will be very difficult to remain in business. I will need your cooperation for this to work for all of us at the facility. If you let me know you're cancelling, I may be able to fill the appointment slot.

•Please do not bring anyone with you to your appointment, unless it is the parent of a minor, or an aide for someone who needs assistance. I will not be allowing visitors at this time & the waiting room at this time is for the facility's clients & those providing necessary assistance to clients only.

FROM THE TIME OF ARRIVAL:

•MASKS: Everyone is required to wear a face mask (that covers the mouth and nose) at all times while in the building. This helps reduce the risk for ALL of us, especially those in the high risk category. If you anticipate difficulty with this, let me know. Please bring a NEW (if disposable) or CLEAN (if re-usable) mask to every session. * If you do not have a mask, you will need to purchase one.

•HAND HYGIENE: You'll be asked to wash and sanitize your hands immediately upon entry into the treatment room, and after the session has concluded at the sink in the private treatment room.

•RESTROOMS: Medical experts state shared restrooms have higher exposure risk. Be aware we have a restroom for your use that is shared with all clients in the facility. Be sure to observe proper hand-washing.

•PHYSICAL DISTANCING: While I am well aware of the practice of social distancing, it is not possible to maintain physical distance between client and therapist during treatment sessions, due to the nature of the manual therapy I provide. I have, however, worked my schedule to maximize distance between clients, and I have avoided overlap in client appointments. When in the faclity observe 6 ft distance between other clients, if/when necessary.

DURING YOUR TREATMENT SESSION:

•Face masks will need to be worn at all times. If you don't feel comfortable or anticipate difficulty with the use of a mask during treatment, I will need to postpone your session. SUGGESTION: If you have not been wearing a mask regularly, please try wearing one around the house for an hour at a time to be sure you are comfortable, before your first appointment.

•If there are changes to your history or any updates between sessions, I encourage you to communicate by calling, emailing, or texting in advance.

•I will need to be extra mindful of staying within your scheduled appointment time, to allow ample time for proper cleaning and sanitation between clients, so please be considerate of this. If you have specific concerns that need to be addressed at your appointment, including questions about your Home Program or self-treatment options, please communicate them in advance, or be sure to ask at the beginning of the session, rather than at the end.

AT THE CONCLUSION OF YOUR SESSION:

•Please have your payment method readily available to conserve time. I currently accept cash or check. If you do not have a future appointment already confirmed, please text immediately following your appointment, and I'll contact you ASAP to schedule. Keep in mind that this is new to all of us and things may change as we learn more. I'll keep you informed along the way, and ask that you do the same. Feel free to ask questions if you have them. Information is the best way to make the best decisions for your health. I am happy to answer questions and to help you have a great experience at *Master's Touch, LLC*!

Master's Touch, LLC

COVID-19 SUPPLEMENTAL HEALTH QUESTIONNAIRE

_____ (initial here) I acknowledge and accept that I am voluntarily entering into the facility in which *Master's Touch, LLC/*its owner operates to receive treatment and care for my injury/condition/pain during the COVID-19 pandemic.

_____ (initial here) I agree to be forthright and truthful in reporting any symptoms and pertinent information to the best of my knowledge and understanding, and I will not expose and/or put *Master's Touch, LLC*/its owner at risk with known or possible symptoms of COVID-19.

1. Have you at any time been diagnosed with COVID-19? (circle one). YES NO

If YES, when was your diagnosis?

2. Within the past 14 days, have you had contact with anyone that has been diagnosed with or has symptoms associated with COVID-19, and/or have you consistently been in any environment(s) that are considered high-risk? (circle one). YES NO

If YES, please explain:

3. Have you recently returned from international/national travel within the past 14 days?

(circle one) YES NO

4. Within the past 7 days, have you had fever/chills, or an elevated temp above 100 degrees?

(circle one) YES NO

5. Within the past 7 days, have you had any headaches, sore throat, nausea, vomiting or

diarrhea? (circle one) YES NO

6. Have you had coughing, especially a dry cough, consistently in the past 7 days?

(circle one) YES NO

7. Have you had difficulty breathing or shortness of breath without exertion, or other respiratory symptoms in

the past 7 days? (circle one) YES NO

8. Have you lost your sense of smell and/or taste in the past 7 days? (circle one) YES NO

Patient Name _____ Date _____
(PRINT)

Patient/Guardian Signature _____

Master's Touch, LLC

COVID-19 SUPPLEMENTAL INFORMED CONSENT & LIMITATION OF LIABILITY WAIVER

Thank you for your trust in *Master's Touch, LLC* for your health care. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Please be assured that I am and will be following state and federal regulations to limit the transmission of all diseases in my office, and I will continue to do so. Despite careful attention to sterilization, disinfection, and added safety measures, including personal protective equipment, there is still a chance you could be exposed to an illness in my office. Additionally, due to the nature of the manual therapy services I provide, it is not possible to maintain physical distance between patient and therapist during treatment sessions.

_____ (initial here) I understand and voluntarily accept all known and unknown risks associated with services provided at *Master's Touch, LLC* during the COVID-19 pandemic, and I consent to treatment.

_____ (initial here) I have been forthright and truthful in reporting my symptoms and any pertinent information to the best of my knowledge and understanding. I will not expose and/or put *Master's Touch, LLC*/its owner at risk with known or possible symptoms of COVID-19. If I develop symptoms or am potentially exposed to COVID-19 at any time, I will immediately contact *Master's Touch, LLC*/its owner.

_____ (initial here) I understand that I may be exposed to additional risks at the facility and agree to protect, indemnify, defend, and hold harmless *Master's Touch, LLC*, and any members, partners, contractors, agents, employees, or successors from and against all loss, cost, damage, demand, expense, penalty, or liability incurred (including property damage, injury, or death) that arises from or is related to Master's Touch, LLC services, precautions, exposure, or virus transmission during COVID-19.

_____ (initial here) I have received, reviewed, and understand the COVID-19 Policies & Procedures, and agree to follow them.

_____ (initial here) I understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

_____
Patient Name (print)

_____ _____
Patient/Guardian Signature Date