Master's Touch

CLIENT INFORMATION

Barb Friscia, MA, LMT, ATC, CAFS
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? _____

Updated 04/03/23

What aggravates/alleviates your symptoms? _____

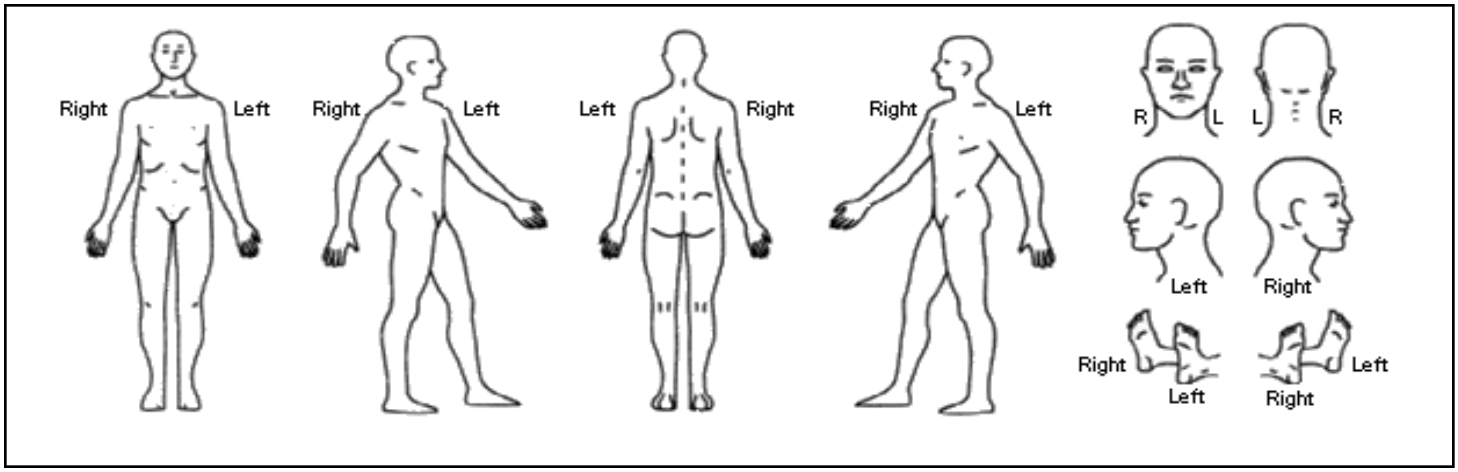
What are your treatment goals? _____

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-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? (circle one). YES NO

If YES, when was your diagnosis?

2. Within the past 5 days, have you had contact with anyone that has been diagnosed with or has symptoms associated with COVID, 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 travel within the past 10 days?

(circle one) YES NO

4. Within the past 5 days, have you had fever/chills, or an elevated temp above 100 degrees?

(circle one) YES NO

5. Within the past 5 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 5 days?

(circle one) YES NO

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

the past 5 days? (circle one) YES NO

8. Have you lost your sense of smell and/or taste in the past 5 days? (circle one) YES NO

Patient Name _____ Date _____
(PRINT)

Patient/Guardian Signature _____

Master's Touch, LLC

COVID 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, 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 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. If I develop symptoms or am potentially exposed to COVID 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.

_____ (initial here) I have received, reviewed, and understand the COVID 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. 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