



Name: _____ DOB: _____

Cell: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____ Occupation: _____

Spouse Name: _____

Referred By: _____

The following information will be used to help plan safe and effective massage sessions. It will be kept confidential.

Have you ever received any type of Covid Vaccine? **YES NO** If Yes, how many shots: _____

Have you had a professional massage before? **YES NO** How often? _____

Do you have any allergies or skin sensitivities? **YES NO** Explain: _____

Pregnant? **YES NO** How far along: _____ Are you wearing Contacts or Hearing Aid? **YES NO**

What is your goal for this massage session? _____

Are you currently taking any prescriptions or over-the-counter medications such as blood thinners, cancer treatments, or anything else that might indicate a condition that's contraindicated for massage? **YES NO** If yes, explain:

Please circle any condition below that applies to you:

<i>Anxiety</i>	<i>Varicose Veins</i>	<i>Depression</i>	<i>High/Low Blood Pressure</i>	<i>DVT/Blood Clots</i>
<i>TMJ</i>	<i>Artificial Joint</i>	<i>Easy Bruising</i>	<i>Headaches / Migraines</i>	<i>Circulatory Issues</i>
<i>Diabetes</i>	<i>Recent Injury</i>	<i>Osteoporosis</i>	<i>Osteo/Rheumatoid Arthritis</i>	<i>Recent Surgery</i>
<i>Numbness</i>	<i>Heart Condition</i>	<i>Spinal Issues</i>	<i>Food Allergy/Sensitivity</i>	<i>Epilepsy/Seizures</i>

Is there anything else about your health history that you think would be useful for your therapist to know?

Additional Questions:

- Do you suffer from a history of PTSD or Abuse? **YES NO**
- Would you like to learn more about reducing anxiety, trauma & blockages? **YES NO**

Client Name: _____ DOB: _____

Covid Vaccine Policy

Initials: _____
Due to higher blood clotting risk which is contraindicated for massage, we do not massage anyone who has had a Covid Vaccine of any kind. Depending on medical history, we will make exceptions for post-surgery cosmetic patients. See required waiver.

Privacy Policy

Initials: _____
All of your personal information will remain confidential unless under orders by law. Your information is kept on secure third party servers. Your personal information will never be shared with 3rd parties. ForeverNow LLC owns several doing-business-as programs and will send information about those programs. **You agree to receive emails and texts containing upcoming appointments, follow ups, and the occasional sales notice.** See HIPAA form for additional information.

Consent for Treatment

Initials: _____
If I experience any pain or discomfort during this and each future session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

Initials: _____
I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Initials: _____
Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Initials: _____
I agree to the potential use of aromatherapy or therapeutic grade essential oils during my treatment or will inform the practitioner of my desire not to do so. Understanding all of this, I give my consent to receive care.

→ Client Signature: _____ Date: _____

Client Name: _____ DOB: _____

Payment Process and Agreement

Initials:

Cancellation Notice: I understand that if I fail to keep an appointment without a **2 hour notice of cancellation** (unless it's a justifiable emergency), **I will occur a \$50 no show fee or lose 30 minute of package time.** This fee is in effect for ALL appointments – even voucher & gift certificate holders, free massages, etc.

Initials:

I understand that all payments are due at the time of the massage. A receipt can be requested for any reason to include: insurance reimbursement, HSA reimbursement, etc. I agree to pay for massage with cash, check, Cash APP, Venmo, Zelle, PayPal, Visa, MasterCard, Discover or American Express.

Initials:

Discount Voucher Program: Packages are **NON REFUNDABLE**. I understand that all packaged deals include vouchers redeemable for massages. These vouchers ARE transferable and expire within 12 months of issue date.

Initials:

Voucher Terms & Conditions: Vouchers are NON-REFUNDABLE. If you fail to use the vouchers by the expiration, they will become null and void. Every effort will be given by the therapist to help you schedule your appointments in a timely manner as to avoid default. Should the scheduling fail due to the fault of the therapist, an extension will be authorized. These vouchers are part of a discount program designed to make massage more affordable through bulk prepaid vouchers. They are not a gift certificate as it is assigned through a discount voucher program. Participating in just 1 massage per month would satisfy all the vouchers in a timely manner.

Understanding all of this, I give my consent to process payments for treatment and/or services. I agree to the terms listed above.

→ Client Signature: _____

→ Printed Name: _____

→ Consent Agreement: Date: _____

FOR VA Community Provider Network ONLY. Veterans with a VA Authorization Referral must complete this section. To facilitate the billing of insurance for massage therapy services, ForeverNow LLC requires consent from clients for the use and disclosure of their PHI to insurance providers for the purpose of payment.

Client Name: _____ DOB: _____
Social Security #: _____ VA Authorization #: _____

Consent for Billing and Insurance Communication By signing below, you authorize ForeverNow LLC aka ForeverNow Massage & Coaching to:

Initials:

- Submit claims and supporting PHI to your insurance company for reimbursement of services provided.
- Communicate as necessary with your insurance provider to obtain payment for services rendered.
- Disclose relevant health information to your insurance provider, including treatment plans, dates of service, and any other details required for claim processing.

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- Disclose relevant health information to your insurance provider, including treatment plans, dates of service, and any other details required for claim processing.

Client Responsibilities:

Initials:

- You acknowledge that you are responsible for any charges not covered by your insurance provider.
- You agree to inform [Practice Name] of any changes to your insurance coverage.

Understanding all of this, I give my consent to process payments for massage and I agree to the terms listed above. Furthermore, I consent to the use and disclosure of my PHI for the purposes of billing and insurance reimbursement.

→ Client Signature: _____

→ Printed Name: _____

→ Consent Agreement: Date: _____