Pikes Peak Wellness at 405 S Cascade Ave Suite 205, 80903

Name_____ DOB_____/_____/_____

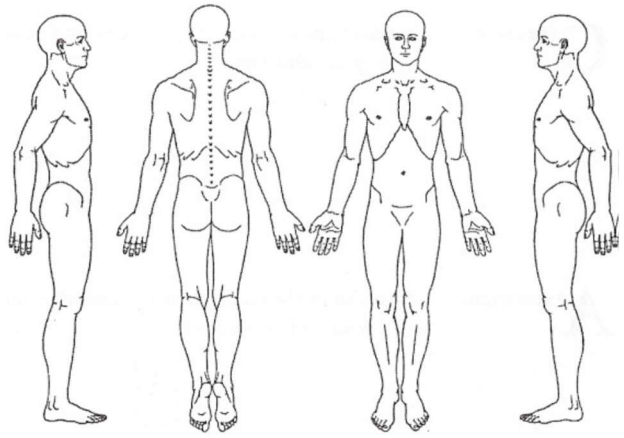
Occupation_____ Activities _____

Phone H / M / W_____ Email _____

Physician/Phone _____ (___) _____ Emergency Contact/Phone_____ (___) _____

Have you ever received massage therapy? ___Yes ___No

If yes, when was your last massage? _____ How often do you receive massage? _____



What are your goals for massage?

___Relaxation ___Tension Relief

___Injury Recovery ____Maintenance

What type of touch do you prefer?

____Mild ____Moderate ___Deep

Circle or 'X' and describe the areas of your body you would like the therapist to focus on:

_____

_____

_____

Are there any medical conditions/injuries the therapist should be aware of? ___Yes ___No

If yes, please explain: _____

_____

Do you have any allergies? ___ Yes ____ No If yes, please explain: _____

Are you pregnant ____ Yes ____ No If yes, how many weeks _____

Are you taking any medications at this time? If so what type: _____

- ☐ I have read and understand all policies of services done by Pikes Peak Wellness and its team of Massage Therapists
- ☐ I certify that the above information is complete and correct and will keep therapist informed of any changes
- ☐ I understand I will be financially responsible for any scheduled appointment which is not cancelled 24 hours in advance
- ☐ I understand that neither Massage Therapists of Pikes Peak Wellness will be liable for any injuries or loss sustained to myself or property while on PPW Place of business at: 405 S. Cascade Ave Suite 205, Colo Spgs, CO 80903

Client: _____ Date:_____

Therapist:_____ Date:_____

Massage Clinic Policies:

Cancellations/No Shows/Appointment Changes: Pikes Peak Centering strongly enforces a **24 hour cancellation policy**. Any cancellations or changes to appointments must be made **at least 24 hours prior** to the appointment. Our wish is not to inconvenience you; only to ensure a firm commitment for each appointment. There is a sincere scheduling of care and substantial reservation of time commitment made leading up and processing after each appointment. Should Pikes Peak Wellness have to cancel your appointment within 24 hours for any reason, an affirmation of scheduled therapist that day has resorted to all avenues in seeking a substitute for your appointment, but unable to do so. If cancellation by Therapist is made within 3 hours of scheduled appointment, an issuance of credit for 50% off next session will be provided.

Appointments/Reservations:
Appointments must be made at least 24 hours ahead of desired date/time with Pikes Peak Centering, with requested services and length.

Late Arrivals: If you arrive late, your massage/treatment will last for the remaining appt time. However, you will still be responsible for full payment of the requested service for the time allotment reserved. PLEASE intend to arrive 10 mins before appt time to ensure On-Time start time.

Confirmation of Appointments: Pikes Peak Centering will do its best to provide you with a confirmation message the day before your appointment; however, this is considered a *courtesy* message and is NOT a guarantee. So, whether or not you receive a confirmation notification, you are still responsible for keeping your appointment time. *Client consents that Pikes Peak Centering may leave a message regarding appointments with whoever views the email/text, or answers the number given or with left on voicemail.*

Emergency Policy: In the event of weather emergency conditions, please contact Pikes Peak Centering ***prior*** to your scheduled appointment.

Clinic Facility Behavior: We emphasize proper, moral, and professional behavior in the massage studio/facility. Any improper remarks or behavior will not be tolerated and can result in immediate and possible permanent dismissal from massage therapy services and care, and automatic cancellations of future existing appointments without refund if paid ahead of time.

Children: We strongly encourage clients to **not** bring child(ren) with them to their massage session as we cannot be responsible for their care and must ensure a relaxing environment for all of your personal needs. If it is absolutely necessary for you to bring your child(ren), then we will request that they remain in the massage room with their parent/guardian while the massage is being given for the privacy of those in the waiting area.

Safe Sport: In respect to young athletes/clients in care below the age of 18 years, there MUST be a guardian present in the room. It is HIGHLY preferred that at least shorts and a sports bra/tank top remain clothed of the athlete/client. For those 18 or older have full decision of clothing status for treatment preformed. DRAPING, as is required by state law, will be used for massage treatment, except sport massage as this discipline is conducted fully clothed in athletic wear as a warm up or cool down of athletic activity.

Professional Confidential Agreement: It is Pikes Peak Centering' policy to follow HIPPAA (Health Insurance Portability and Accountability Act) standards in keeping services/treatments confidential unless noted to share/not share care information to the following person(s) listed below. **If under 18 years**, signature of a guardian is required in addition to athlete/client.

HIPAA Release Form:
Section 1: I,_____, *(circle one)* **GIVE / DO NOT GIVE** my permission for Pikes Peak Wellness to share information of massage treatment/care with the person(s) or organization(s) I have authorized below, or list All That Acquire About Me.

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____

(Parental/Guardian Signature if client under 18 yrs)_____ Date: _____

Section 2: I understand that: • At any time, I am allowed to revoke/update permissions of sharing treatment/care information to the person(s) or organization(s) listed above. • In the event that my information has already been shared by the time I revoke my authorization, it may be too late to cancel permission to share my health data upon date of change. • I understand that the failure to sign/submit this authorization or the cancellation of this authorization can and will prevent services I have requested to receive.

Signature: _____ Date: _____
Print your name: _____

***If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor, please complete the following information:*

Printed Name *of person completing this form:* _____
Signature *of person completing this form:* _____

Supervision (Treatment/Care for individuals under 18 yrs): Parent/Guardian in observation of treatment MUST have phone in Do Not Disturb/Mute and must use personal hearing device for personal devices in order to not disturb the session. Questions, comments or concerns during any time of the session is permissible and allowed with consideration of relax state of client

_____
Signature & Printed Name *(of **Minor**)* Date

_____
Signature & Printed Name *(of **Parent/Guardian if applicable**)* Date