Body Kneads Massage
Give the Body What it Kneads

13955 W Preserve Blvd., Suite 200, Burnsville, MN 55337
Phone: (952) 890-0804 | Fax: (952) 890-

Body Kneads Massage Minor Consent Form & Intake Paperwork

Minors are permitted to receive massage in our facility with parental or legal guardian consent. Please read the guidelines bulleted below before giving consent to the minor's massage therapy session.

- Parent or legal guardian must be present in helping complete the New Patient and Health History Intake paperwork for the minor, along with this consent for the massage therapy session.
- All patients under the age of 18 can ONLY receive massage with written parental/legal guardian consent. In collaboration with the consenting adult and child, the massage therapist will assist in establishing goals for the session(s).
- Appropriate draping will be used at all times during the massage, only areas being massaged are uncovered.
- All patients under the age of 13 MUST ALWAYS have a parent/guardian present either in the treatment room OR within the Body Kneads Massage or Northern Life Wellness facility.
- If both client and parent/guardian are comfortable with the child being in the session room by themselves, please initial here. _____ (Initials)

By signing below, you agree that you are the parent or legal guardian of the minor receiving treatment(s) at our facility. You understand that you have the option to remain at the facility for the entirety of the minor's treatment(s) and are required to do so if the minor is under the age of 13. As the parent or legal guardian, you may also request that you remain in the treatment room to supervise all interactions between the therapist and the minor at any time. You agree that you have completed the Intake Form and have informed the therapist of all medical diagnoses, symptoms, medications, and complaints associated with the minor receiving treatment(s). You are aware of this legal waiver that is in full effect with this signature for the person receiving the services as well as yourself.

Signature of Parent or Guardian: _____

Today's Date: _____ Therapist Initials: _____

Body Kneads Massage New Patient Paperwork

Patient Information:

Name _____ DOB____/____/____

Patient Cell Phone_____ Guardian Phone: _____

Address_____ City_____ State_____ Zip_____

E-mail _____Guardian E-mail _____

Guardian Occupation _____ Referred By_____

Have you been in an auto accident? □ Yes □ No Date of Accident _____

Worker's Comp claim? □ Yes □ No Date of Incident _____

Are you interested in □ Physical Therapy? □ Chiropractic?

Are you Pregnant □ Yes □ No *If Yes, answer the following questions.*

How far along are you? _____Weeks
Are you comfortable face down? □ Yes □ No
Are you high risk? □ Yes □ No

Have you ever experienced a professional massage or bodywork session? *Yes or No*

If so, how recently? _____

What are your massage or bodywork goals? _____

_____

What kind of pressure do you prefer? □ Light □ Firm □ Medium □ Deep Tissue
Comments_____
_____

Please list all medications: _____
_____

Please list all medical conditions: _____
_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

If you answer "yes" to any of the following questions, please explain as clearly as possible below.

□ Yes □ No Do you frequently suffer from stress? Explain.
□ Yes □ No Do you bruise easily?
□ Yes □ No Do you have diabetes?
□ Yes □ No Any broken bones in the past 2 years?
□ Yes □ No Do you experience headaches? Explain.
□ Yes □ No Any injuries in the past 2 years?
□ Yes □ No Do you suffer from arthritis? Explain.
□ Yes □ No Do you suffer from back pain? Explain.

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□ Yes □ No Are you wearing contact lenses?
□ Yes □ No Do you have numbness/stabbing pains? Explain.
□ Yes □ No Do you have high blood pressure?
□ Yes □ No Are you sensitive to touch or pressure? Explain.
□ Yes □ No Do you suffer from epilepsy or seizures?
□ Yes □ No Have you ever had surgery? Explain below
□ Yes □ No Do you suffer from joint swelling? Explain.

□ Yes □ No Do you have any contagious diseases?
□ Yes □ No Do you have varicose veins? Explain.
□ Yes □ No Do you have osteoporosis?
□ Yes □ No Do you have any allergies? Explain.
□ Yes □ No Cardiac or circulatory issues? Explain.
□ Yes □ No Do you have warts, ringworm, or corns?

Comments_____
_____

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the therapist 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, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists 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 should be construed as such.

Because massage should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so. **I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.**

Signature of Client Date

Signature of Client or Guardian Date

Scheduling and Cancellation Policy

Body Kneads massage appreciates that you have chosen our facility for your massage and body work sessions. We strive to provide you with top notch care. We would like to communicate some guidelines and policies in order to provide you with an exceptional session.

Body Kneads Massage asks that you respectfully give a 24-hour notice of cancellation. If you cancel your appointment with less than a 24-hour notice, you will be charged half of the regular fee. If you miss your entire appointment session without the proper cancellation procedure, you will be responsible for the customary fee for the session.

Your appointment with Body Kneads Massage is reserved for you and we understand there are scheduling adjustments that are necessary. Please know that when you forget to cancel your appointment without

proper notice, other practice members are not afforded the opportunity to fill those times and are forced to wait until the next available appointment time. We appreciate your understanding and patronage and look forward to serving you to the best of our ability and delivering the highest quality patient care available.

We understand that issues occur. It helps us a great deal if you call and let us know if you will be arriving late. We will do our best to accommodate you. If you arrive late, you will be charged for the entire session and only be granted the remainder of that session if there is a scheduled appointment behind yours. In return, we will make sure that we are on time, and if for some reason we are not, we will give you the time back or adjust the price of the session.

Children are welcome to join you for your massage session if you are unable to find care for them. However, we strongly encourage you to find alternative care, if at all possible, as they are a distraction to both you and your therapist. If you need to bring a child or children along with you to your massage, they must accompany you into the massage room. Body Kneads is not liable for your children or possessions during a massage.

To ensure your desired appointment time we recommend that you make your appointments in advance. Please arrive five to ten minutes ahead of your scheduled appointment time. This will allow you to fill out any necessary paperwork, as well as give the therapist time to ask specific questions about any health issues or your specific body needs for that session. From the therapist's side, it gives them the full time to actually have their hands on your tissues, keeps our business on schedule, and respects the next clients scheduled therapy time.

Signature of Client or Guardian Date

Financial Responsibility Agreement

Please take a few minutes to read the following financial responsibility statements upheld by our clinic. This form is used to prevent any misunderstandings and to provide our patients with a clear understanding of our billing procedures. If you have any questions, please let us know prior to signing the agreement.

Responsible Party Clearly Defined

Payment in full is due on the date of service unless you have active insurance with benefits remaining that are applicable to the procedures being performed. Our office extends a line of credit for the full amount of the procedure to allow processing time for your health insurance claims. It is understood that the clinic will diagnose treatment based on your health and not your insurance coverage. You are financially responsible for all charges whether or not paid by insurance.

Time Limit to Insurance Claim Processing & Payment Terms and Conditions

All balances remaining open at 60 days are due in full, regardless of pending insurance claims. We will file your insurance claim in order to help you achieve your maximum allowable benefits, but we cannot extend credit beyond 60 days. If you believe that you will need longer than 60 days to pay your charges, please speak to your Doctor or contact our billing department. If the insurance company pays our office after you've paid the balance due, we will issue a refund check to the responsible party and mail it to the address listed on the account.

Additional Interest, Charges and Fees

Monthly charges may also include a $3.00 statement fee. If a check is returned due to insufficient funds or otherwise, a $30.00 return check fee will be added to the account and interest charges may apply.

Collection Activity and Additional Charges

Patient accounts with balances open at 90 days may be subject to more aggressive collection efforts and turn over to a collection agency or an attorney's office. Accounts that are turned over for third party collections will accrue a finance charge which is consistent with the maximum allowable by law and all charges incurred in the recovery of the delinquent account will be added to the patient's account balance. These charges include, but are not limited to, collection fees, reasonable attorney's fees whether litigation is commenced or not, transaction fees, NSF fees, other legal fees and court costs. These recovery costs may increase a patient's balance by as much as 50%.

I have read, understood and agree to the provisions of the Body Kneads Massage Financial Responsibility Agreement:

Signature of Client or Guardian Date

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing. I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the cell phone number indicated in Section C or currently on file.

I authorize to receive email/text messages for appointment reminders and general health reminders/feedback/ information in the Patient Portal to the email address indicated in Section C or currently on file.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details.

I understand that I have the ability to opt-out of such communications at any time by replying STOP. However, I acknowledge that doing so will no longer allow for me to receive text or email communications of any kind including appointment reminders.

I understand and to consent to all email and text communications outlined above.

Signature of Client or Guardian Date