BRIDGETOWN BODYWORK

Aarisa Smith, LMT #15732 ~ 443 NE Knott St. ~ Portland, OR 97212 (760) 613 – 5022

Date:_____

Name (legal)		Pronouns	she/her || he/him || they/them || _____
Name (for use)		Contact #(s)	
Address		Email	
City, State		Referred by:	
Zip		DOB	

Emergency Contact		Relationship		Phone #	

PLEASE CHECK IF APPLICABLE (leave blank if not) AND DESCRIBE

Allergies (Skin & Other)		
Injuries		
Surgeries (type & date)		
Auto/Other Accidents (date/description/treatment)		
Heart Conditions, High/Low Blood Pressure		
Cancer (Type/Date/Treatment)		
Varicosities/Stroke/Clotting Conditions/Sickle Cell		
Epilepsy/Seizures/Neurological Conditions		
Skin Conditions(eczema,psoriasis,etc)		
Arthritis/Other Joint or Spine conditions		
Osteoporosis/Osteopenia		
Asthma/Other Respiratory issues		
TMJ/Headaches/Migraines		
Diabetes/other endocrine conditions		
Autoimmune disorder		
Current Pregnancy		
Medications/Supplements (name/purpose)		
History of trauma/concerns around touch		insights on the best way to work together so you can feel comfortable & in control, and things to do or avoid are welcome
Other medical conditions/comments		

What physical activities do you engage in/how do you use your body on a typical day? _____

_____

How frequently do you receive massage?_____Date of last massage?_____

Current areas of concern?_____

_____

Treatments received/remedies attempted for this issue? _____

Activities which help/make worse?_____

MD/DC/PT/LAc/ND Information (If Applicable)_____

CONTAGIOUS CONDITIONS AGREEMENTS

____ I understand that close contact with people increases the risk of infection from COVID-19 and other illnesses, and acknowledge that I am aware of the risks involved, and give consent to receive massage from this practitioner. I will not hold Bridgetown Bodywork and Aarisa Smith LMT 15732 liable in the event that an infection occurs which may be traced back to this facility and interactions which took place there.

____ Prior to every session, if any of the following apply, I will cancel or reschedule. **I will NOT knowingly come in and expose the practitioner, other clients and building occupants, and their families and associates to the risk of communicable illness:**

- I have been asked to self isolate/quarantine by a doctor or public health official in the last 14 days
- I have traveled to an area designated as high risk by the CDC or WHO within the last 14 days.
- Within the last 7 days I have been in close contact (within 6 feet outdoors, sharing a room indoors, or any member of your household regardless of time spent or distance) with someone for a total of 15 minutes or more over any 24 hour period, who had a communicable illness, or came down with a communicable illness within 2 days of our contact. Communicable illnesses include cold, flu, COVID, hand foot and mouth disease and others.
- I have myself experienced any cold or flu-like symptoms in the last 5 days.
- I have any communicable skin or eye condition, including pinkeye, scabies, lice, athlete's foot etc. etc.

____ I will follow all guidelines for safety as requested, which may include wearing a mask over both my mouth and nose for the duration of the session, and should I feel unable comply, I will not schedule a session with this practitioner. I understand that if I fail to comply with safety requests,, and have to be asked to correct this failure more than once, the session will be terminated, and no refund will be provided.

CONSENT STATEMENTS

_____ I understand that the bodywork practitioner **does not diagnose** illness, disease, or any other physical or mental disorder. The practitioner does not prescribe medical treatment of pharmaceuticals, **nor does he/she perform any spinal manipulations**, though occasional movements may occur in the course of normal soft tissue work.

_____ I understand that massage therapy and bodywork services offered today and in the future are **not substitutes for medical examination**, diagnosis, or care and it is recommended that I see a medical practitioner for any physical ailment that I may have. I understand that any **information provided by the therapist does not represent a medical suggestion, is not diagnostically prescriptive** in nature, and I am fully responsible for doing my own research or consulting a specialist as indicated before undertaking any actions from such information.

_____ **I certify that I do not have any untreated medical conditions and that the above information is complete and accurate. I agree that it is solely my responsibility to notify the massage therapist of any changes in my health or medical condition.**

_____ By signing this release, I hereby **waive and release** Aarisa Smith and Bridgetown Bodywork from any and all liability, past, present, and future relating to massage therapy and bodywork.

_____ I understand the therapist may end the session for inappropriate behavior and I will still be financially responsible for the full session,

_____ I understand that **my information is not disclosed without my written consent** (or consent of parent/guardian) **unless required by law**, that the below provisions constitute consent in those circumstances, and that I may revoke consent at any time. I understand I have been provided the Notice of Privacy Practices, and may at any time request to see that notice, which may be revised periodically.

_____ I understand if I cancel my session with less than 48hrs notice for reasons other than illness or emergency, I will be responsible for the full session cost, & if insurance is filed for a session, **I am financially responsible** if the claim is not paid within 6 months for any reason.

_____ I understand that this facility is **fragrance free** and I will refrain from applying any fragranced products, including deodorants, hair spray, perfume, and anything else, the day of my session, including, where possible, items laundered with fabric softener.

_____ I understand that if I choose to receive **cupping therapy or gua sha that there may be marks** associated with the treatment, and I understand that this treatment is not appropriate for individuals on blood thinners or with bleeding disorders such as hemophilia or sickle cell anemia and will update the therapist if my medication/health status changes at any time.

_____I acknowledge it is **my responsibility to communicate** with the therapist if anything is uncomfortable during the session as well as any changes to my health status and information (the therapist really appreciates this!!!).

_____I **authorize communication to the unsecured email** provided about appointment times and other treatment related information.

_____I **authorize communication by text** to the cell-phone number provided about appointment times & other treatment related information.

_____I **authorize voice mail messages** to the phone numbers provided regarding apointments and treatment related information.

_____I authorize release of my records to my other medical providers, and any attorneys or insurance companies involved in any claims for which Bridgetown Bodywork/ Aarisa Smith LMT 15732 is billing.

_____I **authorize written and verbal communication with my medical providers** regarding my care.

_____I authorize any applicable insurance company to pay directly to Aarisa Smith, LMT all benefits for sessions that may be covered, and hereby consider this an assignment of benefits to Aarisa Smith, LMT/ Bridgetown Bodywork. I further authorize Aarisa Smith, LMT/Bridgetown Bodywork to provide all information my insurance company(s) request regarding treatment. All services not covered or allowed by insurance are my full financial responsibility, and will be paid within 30 days of my notification of the insurance determination.

____I authorize communication with the listed individual(s)or organizations _____ regarding my (circle or cross out) treatment, appointment times, billing, other subjects that may have been discussed.

___I declare that the information provided above is **true and accurate** to the best of my knowledge. I will immediately **inform the therapist if there are any changes to my health status or consent.**

Signature_____Date_____

Parent/Guardian Signature (If Under 18)_____Parent/Guardian Phone#_____