PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ **Date:** _____ **Referred by:** _____

Date of Birth: _____ **Occupation/Employer:** _____

Address: _____ **City/State/Zip:** _____

Phone (H); _____ **(W):** _____ **(Cell):** _____

Email: _____

Primary Healthcare Provider: _____ **Phone:** _____

Permission to consult with primary provider? Please initial if yes: _____

Emergency contact: _____ **Contact Phone:** _____

MASSAGE HISTORY

Have you ever received a professional massage: _____ **If yes, frequency:** _____ **Date of last massage:** _____

What results do you want from you massage session? _____

_____

Prioritize areas of your body that you would prefer to be massaged: _____

_____

Are there any areas of your body that you prefer not to be massaged? _____

Are you currently seeing a medical practitioner? Please explain if yes _____

_____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if yes _____

_____

List stress reduction and exercise activities. Include frequency _____

_____

_____

___

List current medication, including aspirin, ibuprofen, etc. _____

_____

_____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries: _____

_____

_____

Accidents: _____

_____

UMA CLINIC
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HEALTH HISTORY

MUSCULO-SKELETAL
Bone or joint disease _____
Tendonitis _____
Bursitis _____
Broken/fractured bones _____
Arthritis _____
Sprains/strains _____
Low back, hip, leg pain _____
Neck, shoulder, arm pain _____
Headaches/Head injuries _____
Spasms/cramps _____
Jaw pain/TMJ _____
Lupus _____
Other _____

CURULATORY
Heart condition _____
Varicose veins _____
High/Low blood pressure _____
Lymphedema _____
Breathing difficulty _____
Sinus problems _____
Allergies _____
Other _____

INFECTIOUS/AUTOIMMUNE DISEASE
HIV/AIDS _____
Disease name(s): _____
_____

SKIN
Allergies _____
Rashes _____
Athletes foot _____
Warts _____
Other _____

DIGESTIVE
Constipation _____
Gas/bloating _____
Diverticulitis _____
Irritable bowel syndrome _____
Other _____

NERVOUS SYSTEM
Herpes/shingles _____
Numbness/tingling _____
Chronic pain _____
Fatigue _____
Sleep disorders _____
Other _____

REPODUCTIVE
Pregnant? Stage _____
PMS _____
Other _____

OTHER
Cancer/tumors _____
Diabetes _____
Eating disorders _____
Depression _____
Drug/alcohol addiction _____
Nicotine/Caffeine Addiction _____

It is my choice to receive therapy; I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my wellbeing is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

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SIGNATURE: _____ **DATE:** _____

APPOINTMENT POLICIES

Please realize that when you set your appointment up that it is for a specific amount of time. Late arrivals are not granted extensions but will receive the remainder of their scheduled session.

Should the circumstance arise where you need to cancel or reschedule an appointment a *24-hr notice is required*. **Failure of giving the required notice will result in a cancellation fee of the full rate of the missed appointment** *($90-$140)*. You are personally responsible for this fee, and its payment is required before your next scheduled appointment.

I hereby agree to the above stated charge and agree to pay the above stated fee.

_____ _____

Patient Signature **Date**

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Release of Liability & Participation Agreement:

Like the practice of medicine, Massage Therapy, Lymph Therapy, CranioSacral Therapy, Neuromuscular Therapy, Intra-Oral Therapy, and any other manual modality performed **by *Erica L. Eickhoff and or Obstacle Busters, and/or Uma Clinic***, as well as Transformation Coaching, Healing From the Core, NLP, Clinical Hypnotherapy, Regression Therapy and Self-Hypnosis, are not absolute sciences. As a general practice, it is necessary for everyone taking part in private sessions, classes, workshops and seminars with ***Erica Eickhoff, and/or Obstacle Busters, and/or Uma Clinic*** to sign this Release of Liability Agreement.

I am of legal age, and in consideration of my acceptance as a participant in this Private Session, Seminar, Workshop, I for myself, my heirs, my executors, administrators and assignees, do hereby release and discharge Erica Eickhoff and/or Obstacle Busters/ Uma Clinic and any of her employees, her employer, or other participants in any of the activities, from all claims of damages arising from, or growing out of my participation in said activities. I agree that any claim of damages or disputes arising from my participation in any private sessions (Any and all modality performed by Erica L. Eickhoff, Uma Clinic and or Obstacle Busters), and any all group sessions, classes and/or workshops, processing emotions methods, guided imagery, or events, should it arise, shall be settled by binding arbitration before an extra-judicial arbitration and mediation service selected by the parties. I further understand that recordings may be made at any of these events, and that Erica Eickhoff, Obstacle Busters/ Uma Clinic and retain the copyright to all of these recordings.

Signature _____ **Date** _____

If under eighteen years of age:

Legal Guardian: _____ **Date** _____

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PERSONAL HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

• Treatment means providing, coordination, or managing health care and related services by one or more health care providers. And example of this would include a physical examination.

• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

• Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

• The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
• The right to inspect and copy your protected health information.
• The right to amend your protected health information.
• The right to receive an accounting of disclosures of protected health information.
• The right to obtain a paper copy of this notice from us upon request.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you Notice of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices from.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Signature: _____ **Date:** _____

Patient Name: _____

Relationship to Patient: _____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE: _____INITIALS: _____REASON: _____

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