Hillsborough Massage Therapy - Client Intake Form

Please PRINT all information

Name: ____ Male Female

Address :____

City: ____________________________________ State: ___________ Zip: _________

Date of Birth: _____/_____/_______ Email for Confirmations ________________________________

Preferred Phone #:______________________ Secondary Phone #: ____________________

Occupation/Type of Work: ____

In Case of Emergency, Please Notify: Name: _____________________________________

Telephone #:___________________ Relationship: ________________________________

Other Information: If employed, what town: ____

Number of Children: ___________ *Ages:* ____

Preferred Appointment Day and Time, if any: ____

How did you hear about us? ____

Hillsborough Massage Therapy - Informed Consent

I, ___________________________________, (*client*) understand that massage and bodywork therapy provided by Hillsborough Massage Therapy LLC are intended to promote and maintain the health and well-being of the client. Massage and bodywork therapies do not include the diagnosis of illness, disease, impairment or disability. If I experience any pain or discomfort during the session, I will immediately inform the therapist so that the pressure and/or manipulations may be adjusted to my level of comfort.

Because massage and bodywork therapy may be contraindicated due to certain medical conditions, I affirm that I have informed the therapist of all my known medical conditions and will keep the therapist updated as to any changes in my medical condition.

Client Signature______________________________________ Date ___________________

Parent/Guardian Signature if Under 18:_________________________ Date: ______________

Hillsborough Massage Therapy – Health Information

Allergies _______	Chronic Fatigue _______	Phlebitis ________	Tightness-Range of Motion ___
Arthritis ________	Constipation __________	Ringing in Ear ____	TMJ Problems _____________
Asthma ________	Fibromyalgia __________	Seizures _________	Varicose Veins ____________
Blood Clots ______	Headaches __________	Sinus Problems ____	Visual Problems ___________
Blood Pressure ____	Heart Disease ________	Skin Rashes ______	Diabetes _________________
Broken Bones ___	Joint Pain __________	Surgery _________	Nut Allergies ______________
Cancer ________	Persistent Stress ______	Stroke __________	Other ____________________

Please list medications you take:____

Health information or items of importance as they may relate to massage therapy:___________________

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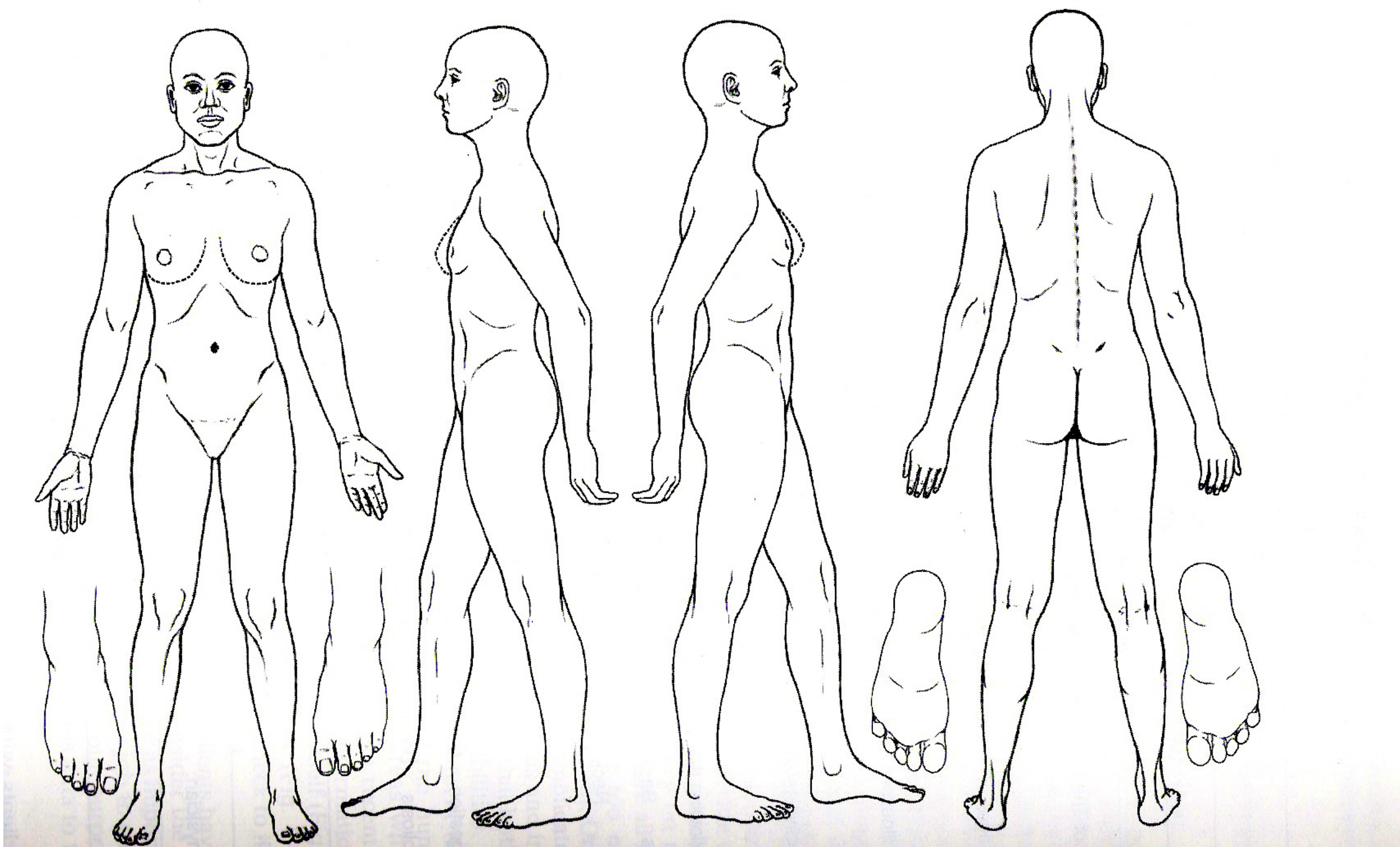
Please mark or circle any particular areas of concern. You may wish to describe your concerns, also.



"The Very Best In Massage"
601A Omni Dr, Hillsborough, NJ 08844
P: (908) 359-5777 F: (908) 248-0900
www.HillsboroughMassage.com
info@HillsboroughMassage.com

HIPAA Notice of Privacy Processes
(Health Insurance Portability and Accountability Act)

We want you to know as a client, we hold your information extremely confidential. Your records of health are secure and are not easily available for anyone's viewing.

Use and Disclosure of Your Protected Health Information

Hillsborough Massage Therapy LLC (HMT) will not use or disclose your Protected Health Information (PHI) for any purpose unless you have signed an authorization for it's use and disclosure. You have the right to revoke that authorization in writing at any time. HMT will only discuss your PHI with another medical facility provided that their services are related to your session(s) with us.

Your PHI may be disclosed by law or subpoena:
- If for public health concerns, such as a disease.
- If required by law, such as suspected child abuse.
- If you are a victim of abuse or domestic violence.
- If required by law, to a government agency covering investigations.
- If required to do so by a court or subpoena.
- If for National Security, your PHI can be given to the military.

As a client, you have an opportunity to know what information is being held regarding your health maintenance. Requests for a copy of your records must be placed in writing.

Please send any concerns if you feel that your privacy has been violated to:
Hillsborough Massage Therapy LLC, Attn: Privacy Officer
601A Omni Drive, Hillsborough, NJ 08844

Please allow us to resolve your concerns prior to filing your complaint within 180 days to:
Secretary of U.S. Department of Health and Human Services
200 Independence Avenue, S.W., Washington, DC 20201

I have received a copy of this office's Notice of Privacy Processes.

Client Name (Please Print) ______________________________

Client Signature: ________________________________ Date: ________________________

Parent/Guardian Name If Under 18 (Please Print) ____________________________________

Parent/Guardian Signature ________________________________ Date: ________________

A family member or friend can receive your PHI **ONLY** with your prior written approval. Is there a family member/friend that we have approval to release your PHI to if necessary? This may be left blank. You may enter more than one name. More names may be added by you, in writing.

Designated person (Please Print) __________________________ Phone # ____________

Designated person (Please Print) __________________________ Phone # ____________