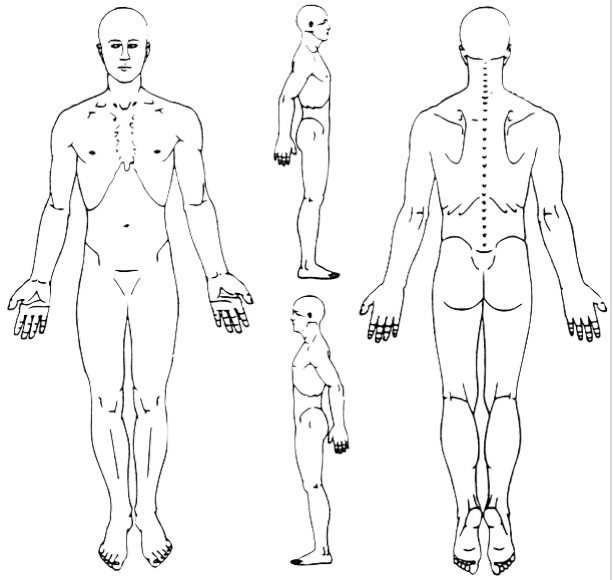
HILLSBOROUGH
MASSAGE THERAPY LLC

Prenatal Client Intake Form (Please PRINT)

CLIENT INFORMATION				
Full Name:		DOB:	Expected Del. Date:	
Address:		City:	State:	Zip:
Email Address:		Occupation:		
Home #:	Cell #:	Preferred contact method:		

EMERGENCY INFORMATION		
(Notify) Full Name:	Relationship:	Phone:

HEALTH DATA		Mark Stress Zones:
Reason for visit:		
Circle all that apply:		
Anemia	Morning Sickness	
Blood Pressure High / Low	Pain	
Breathing Problems	Placental Abnormalities	
Contractions	Sciatica	
Depression	Spotting	
Excessive Weight Gain / Loss	Swelling	
Gestational Diabetes	Varicose Veins	
Regular Prenatal Care: Yes / No	Other:	
Describe previous pregnancies & births w/ dates:		
Describe current pregnancy to date:		
Medications:		
Name of Care Provider:		Delivery Hospital:

CONSENT FOR TREATMENT & CANCELLATION POLICY

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure may be adjusted to my level of comfort. I understand that massage/bodywork practitioners 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 given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner'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. Understanding all of this, I give my consent to receive care.

Cancellation Policy: Please call as soon as you know you are unable to come in. Appointments cancelled with less than 24 hours notice are subject to billing.

Client Signature:	Date:

How did you hear about our office? _____

601 A Omni Drive Hillsborough, NJ 08844 ~ 908.359.5777 ~ info@hillsboroughmassage.com

HILLSBOROUGH
MASSAGE THERAPY LLC

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 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 reviewed Hillsborough Massage Therapy LLC's Notice of Privacy Processes.

Client Name (Please Print):	
Client Signature:	Date:

A family member(s) or friend(s) can receive your PHI **ONLY** with your written approval. Please list below any family member(s)/friend(s) authorizing release of your PHI if necessary. Designated person(s) may be left blank.

Designated person (Please Print):	Phone #:
Designated person (Please Print):	Phone #: