OLYMPIC MYOTHERAPY AND MASSAGE
COVID-19 INFORMED CONSENT

Client Name: _____ **Date:** _____ **Time of Service:** _____

1. Have you had a fever in the last 24 hours of 100 F or above? Yes No
2. Do you now , or have you recently had, any respiratory or flu like symptoms , sore throat, muscle pain or soreness, or shortness of breath? Yes No
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronovirus type symptoms? Yes No
4. Have you traveled anywhere outside the State of Washington in the last 14 days? Yes No

COVID-19 is a highly contagious virus that spreads from person-to-person. In addition to long-held and explicit sanitation measures this business adheres to, new preventative measures have been put in place to further reduce the spread of COVID-19. However, these best practices offer no guarantee regarding your potential risk of being infected.

CONSENT FOR TREATMENT:

I understand that, because massage therapy services involve maintained touch and close physical proximity over an extended period of time , there may be an elevated risk of disease transmission, including COVID-19.

By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless this practitioner/business from any claims related hereto.

I give my consent to receive therapeutic massage treatment from Olympic Myotherapy and Massage, Laura J. Dilts, LMT.

Client Signature: _____ Date: _____:

Olympic Myotherapy and Massage
Laura J. Dilts LMT MA 60531598
1700 Cooper Point Road SW, Bldg C-1
Olympia , WA 98502
www.olymyomassage.com

360-529-2224

Client Intake Form – Therapeutic Massage

Name_____ Phone (Day) _____Cell_____

Address_____City/State/Zip_____

Email_____ Occupation _____

Date of Birth_____ Referred by _____

Emergency Contact _____ Phone_____

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? Yes No If yes, how often? _____

Do you have any difficulty lying on your front, back, or side? Yes No

If yes, please explain _____

Do you have any allergies to oils, lotions, ointments, fruits or nuts? Yes No

If yes, please explain _____

Do you have sensitive skin? Yes No

Are you wearing ☐ contact lenses ☐ dentures ☐ a hearing aid ☐ prosthetics?

Do you sit for long hours at a workstation, computer, or driving? Yes No

If yes, please describe _____

Do you perform any repetitive movement in your work, sports, or hobby? Yes No

If yes, please describe _____

How do you feel the stress in your work, family, or other aspect of your life affected your health?

☐ muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other_____

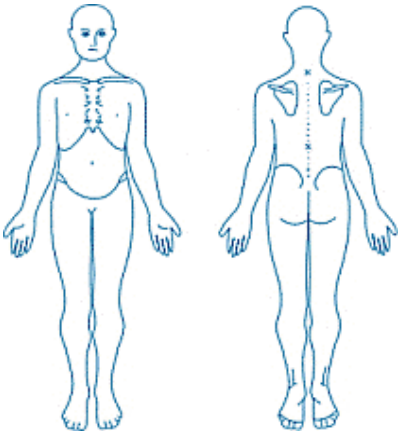
Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort?

Yes No If yes, please identify_____

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain_____

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Medical History

Do you currently or have you ever had any of the following: (please check)

- ☐ phlebitis
- ☐ deep vein thrombosis/blood clots
- ☐ joint disorder
- ☐ rheumatoid arthritis/osteoarthritis/tendonitis
- ☐ osteoporosis
- ☐ epilepsy
- ☐ headaches/migraines
- ☐ cancer
- ☐ diabetes
- ☐ decreased sensation
- ☐ back/neck problems
- ☐ Fibromyalgia
- ☐ TMJ
- ☐ carpal tunnel syndrome
- ☐ contagious skin condition
- ☐ open sores or wounds
- ☐ tennis elbow
- ☐ recent fracture
- ☐ recent surgery
- ☐ artificial joint
- ☐ sprains/strains
- ☐ current fever
- ☐ swollen glands
- ☐ allergies/sensitivity
- ☐ heart condition
- ☐ high or low blood pressure
- ☐ circulatory disorder
- ☐ varicose veins
- ☐ atherosclerosis
- ☐ easy bruising
- ☐ recent accident or injury
- ☐ pregnancy If yes, how many months?

Are you currently under medical supervision? Yes No

If yes, please explain_____

Do you see a chiropractor? Yes No If yes, how often?_____

Are you currently taking any medication? Yes No

If yes, please list _____

Is there anything else about your health history that you think would be useful for your massage therapist to know to plan a safe and effective massage session for you? _____

_____

_____

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 my 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 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 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 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 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.

Signature of client _____ Date _____

Signature of Massage Therapist _____ Date _____

Olympic Myotherapy and Massage

HIPAA NOTICE OF PRIVACY AND CONSENT

HIPAA Notice of Privacy & Consent The purpose of this form is to disclose to you that we comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). We respect your privacy and understand the seriousness of the medical information you disclose to us.

Your Rights as a Client Under HIPAA:
• We must obtain your written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.
• If you authorize a personal representative, we will allow that representative to inspect and receive a copy of protected health information about you The personal representative of a minor child is usually the child's parent or legal guardian.
• Only you or your personal representative has the right to access your client care file. A health care provider or health plan may send copies of your records to another provider or health plan as needed for treatment or payment or as authorized by you.
• We will not deny you a copy of your client care file because you have not paid for the services you have received.
• If you think the information in your client care file is incorrect, you may request that we amend the record.
• If you have any questions or concerns with regards to how your individual client care file for Olympic Myotherapy and Massage is being managed please contact Laura Dilts , LMT by calling (360) 529-2224 or emailing laura@olymyomassage.com. Please place "HIPAA" in the subject line.

Permitted Uses of Your Medical Information & Disclosure Under HIPAA. We are authorized to use your medical information for the following reasons: Treatment, Payment, Health Care Operations:

• **Treatment:** if authorized by you or personal representative we may coordinate with one or more of your medical providers in providing healthcare and related services. This may include actions such as providing or receiving medical referrals and the sharing of documents utilized to obtain your medical related information.
• **Payment:** if necessary, we are authorized to use your medical information to obtain payment or reimbursement for services provided.
• **Healthcare Operations:** (a) Quality assessment and improvement activities, (b) competency assurance activities, (c) conducting or arranging for medical reviews, audits, and legal services, (d) specified insurance functions such as underwriting, risk rating, and reinsuring risk (e) business planning, development, management and general administration, (f) business management and general administrative activities of the clinic. Olympic Myotherapy and Massage 1700 Cooper Point Road SW, Bldg C-1 Olympia, WA 98502 (360) 529-2224 email olymyomassage@gmail.com

Permitted Use of Information without Authorization HIPAA outlines "12 national priority purposes" as justification why your authorization would not be needed to have access to your medical information that if it were requested of us, we would have to provide information pertaining to your records. Those "12 national priority purposes" are:
1. If it is required by law to include statute, regulation, or court order
2. We may be required to disclose protected information to public health activities and agencies such as the FDA or other public health authorities for the purposes of preventing or controlling diseases, to report child abuse, the tracking of products with adverse affects, product recalls, individuals who may have contracted or been exposed to a communicable disease, employers regarding employees in regards to work related illnesses in order for the employer to comply with Occupational Safety and Health Administration (OSHA) or similar state laws.

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HIPAA NOTICE OF PRIVACY AND CONSENT

3. In situations when protected health information is needed to be disclosed to government agencies as it relates to victims of abuse, neglect, or domestic violence.
4. In cases where protected health information is requested for purposes of legally authorized health oversight activities such as audits and investigations necessary for oversight of the health care system.
5. We may be required by judicial or administrative proceeding through a court order or administrative tribunal to provide protected health information. Under this scenario certain assurances may be provided before we disclose your protected health information. 6. We be requested to cooperate with law enforcement in that we may be required to submit to subpoenas, cooperate in identifying or locating fugitive or material witness, comply with law enforcement's request for information about a victim or suspected victim of a crime, inform law enforcement of a person's death if we suspect criminal activity caused the death, if we believe the protected health information is evidence of a crime that occurred in the facility or on the grounds, and if a medical emergency occurs as result of a crime not in the facility or the grounds but the protected health information can identify the perpetrator or victims.
7. For the benefit of decedents we may provide protected health information to funeral directors as needed, coroner, or examiners to identify deceased persons, determine the cause of death, and to perform related functions by law.
8. We have the ability to disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.
9. Protected health information may be utilized without authorization for the purpose of research. Under this provision as long as we have approval from the Institutional Review Board or Privacy Board. This regulation stipulates representations from the researcher that the use or disclosure of protected health information is solely to prepare a research protocol or for similar purpose preparatory to research and that any research of the record must be conducted in our facility.
10. If we determine information in protected client care file has the ability to prevent or lessen serious harm or danger to your safety, we may disclose that information.
11. By law we are required to disclose protected health information to essential government functions if it is in the best interest of executing the military mission, national security concerns, making medical suitability by the U.S. State Department, protecting the President, protecting the health and safety of inmates or employees in correctional facilities, and determining eligibility for enrollment in certain government programs.
12. If requested we may provide protected health information to comply with worker's compensation laws and other similar benefit programs related to injuries or illness.

Protecting your private health information (PHI) is important to us and we will take all precautions to do so as well as comply with the laws regarding PHI as you have read them above.

We encourage you to visit http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html and learn more to about your rights in accordance with HIPAA and your private health information.

_____ _____

Printed Name Signature Date

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CANCELLATION POLICY

You may cancel your appointment without charge if you are feeling uncomfortable with close contact because of COVID-19 concerns or if you are feeling ill.

As we try to co-exist with COVID-19, there will be no cancellation fees occurred at this time.

I would appreciate as much notice as possible but I do know that last minute rescheduling or cancellations are necessary at times.

My main goal and commitment is to provide you with exceptional service in wellness care in the form of therapeutic touch.

If you are feeling even just a little bit ill or have been exposed to someone else who is ill, please reschedule at your earliest convenience. (360) 529-2224 cell phone. www.olymyomassage.com

Stay safe and stay well,

Laura J Dilts, LMT

_____ _____

Signed/Print Name Date

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