

Client Information



Name _____ Phone (_____) _____ DOB _____

Address _____ City _____ State _____ Zip _____

Referred by _____ Phone (_____) _____

In case of emergency: _____ Phone (_____) _____

General & Medical Information

Occupation _____ Male Female Physician _____

Health Insurance Carrier _____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.

Yes No Have you ever experienced a professional massage or bodywork session? How recently? _____

If you answer "yes" to any of the following questions, please explain as clearly as possible.

Yes No Do you frequently suffer from stress?

Yes No Do you bruise easily?

Yes No Do you have diabetes?

Yes No Have you had any broken bones in the past two years?

Yes No Do you experience frequent headaches?

Yes No Have you been in an accident or suffered any injuries in the past two years?

Yes No Are you pregnant?

Yes No Do you have tension or soreness in a specific area?
Please specify _____

Yes No Do you suffer from arthritis?

Yes No Are you wearing contact lenses?

Yes No Are you wearing dentures?

Yes No Do you have cardiac or circulatory problems?

Yes No Do you have high blood pressure?

Yes No Do you suffer from back pain?

Yes No If "yes" to previous question, are you taking medication for this?

Yes No Do you have numbness or stabbing pains anywhere?

Yes No Do you suffer from epilepsy or seizures?

Yes No Are you very sensitive to touch or pressure in any area?

Yes No Do you suffer from joint swelling?

Yes No Have you ever had surgery? Explain below.

Yes No Do you have varicose veins?

Yes No Do you have any other medical condition, or are you taking any medications I should know about?

Yes No Do you have any contagious diseases?

Yes No Do you have osteoporosis?

Comments _____

Yes No Do you have any allergies?

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. 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.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____

**Patient Consent for Use and Disclosure
of Protected Health Information**

MRC Techs, Inc.

I hereby give my consent for MRC Techs, Inc. (hereinafter referred to as the "Practice") to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

The Practice's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Bernadette Bell, our Privacy Officer, at the following address: 1310 Seven Springs Blvd.
New Port Richey, FL 34655

With this consent, the Practice may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, the Practice may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

KEMP CHIROPRACTIC CENTER AND MRC TECHS

I, _____ ("Patient") have read a copy of
Kemp Chiropractic Center & MRC Techs's Notice of Patient Privacy Practices.

Signature of patient or parent or
legal guardian

Date