Lexington Healing Arts Academy

CONFIDENTIAL CLIENT INFORMATION

First Name _____ Middle Initial _____ Last_____

Address_____

City_____ State_____ Zip_____

Phone (Home)_____ (Work)_____ (Cell) _____

Email _____

May we contact you via email for: ☐ Appointment Reminders ☐ Discounts and Promotions

Is this your first massage ever? Yes _____ No _____

Age_____ Date of Birth_____ Gender_____ Occupation_____

Are you now under the care of a physician or other health care provider? _____If so, for what? _____

List any medications/supplements you are now taking_____

_____

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO YOU:

___ Sinus trouble	**___ Fibromyalgia**	**___ Loss of balance**	**___ Diabetes**
___ Loss of smell/taste	**___ Touch Deprivation**	**___ Loss of memory**	**___ Cancer**
___ Asthma	**___ Recent Injury**	**___ Ringing in ears**	**___ Pregnant**
___ Allergy to nut oils	**___ Recent Surgery**	**___ Contacts**	**___ TMJD**
___ Allergies	**___ Arthritis**	**___ Emotional trauma**	**___ Menopausal**
___ Headaches	**___ Painful joints**	**___ Constipation**	**___ Thyroid problems**
___ Anemia	**___ Swollen joints**	**___ Indigestion**	**___ Skin infections**
___ High blood pressure	**___ Numbness**	**___ Nervousness**	**___ Prostate problems**
___ Low blood pressure	**___ Tingling**	**___ Inner tension**	**___ Use tobacco products**
___ Varicose veins	**___ Back pain**	**___ Irritability**	**___ Use alcohol products**
___ Blood clots	**___ Disc problems**	**___ Fatigue**	**___ Sleeping problems**
___ Heart problems	**___ Dizziness**	**___ Depression**	**___ Restless Legs**
___ Stroke	**___ Fainting**	**___ Contagious disease(s)**	**___ Other (please list below)**
___ Herpes			

Is there anything else you would like to state about your physical and/or emotional health before you receive your treatment?

How did you hear of us? _____Internet _____Phone Book _____Event _____Gift ____Ad ____Other
_____Referral If so, please list name: _____

I agree that all the information I have given is true. I hereby authorize receiving massage and understand the massage services are designed to be a health aid and are in no way to take the place of a doctor's care where indicated. Information exchanged is educational in nature to be used at your own discretion. I understand that all therapists/students keep written SOAP Notes on all massage sessions. I understand and agree that any information exchanged with my therapist/student may become part of my permanent records at LHAA.

Signature: _____ Date: _____

CANCELLATION POLICY: When you schedule an appointment, the time is reserved exclusively for you. Therefore, please, if you must cancel your appointment, a 24 hour notice is required in order not to be charged for the appointment. THANK YOU!

Emergency Contact Person: Name_____ Phone (_____)_____

All massages given are therapeutic only. They are completely non-sexual.

272 Southland Drive • Lexington, KY 40503 • 859-252-5656 • Fax 859-288-0087

Lexington Healing Arts Academy

Privacy Notice Summary

This notice describes our policy regarding the use of your medical information. All student therapists, instructors, employees, staff and other authorized personnel who may need access to your medical information are bound by this policy.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting your medical information is important. This notice describes the ways we may use and disclose your medical information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We Are Required By Law To:

1. Keep medical information that identifies you private.
2. Give you notice of our legal duties and privacy with respect to your medical information.
3. Follow the terms of the notice that is currently in effect.

How We May Use and Disclose Medical Information About You

Students and therapist are required to gain medical history information about each client receiving a massage. The information is used for some or all of the following reasons: for treatment, giving chair or table massages; for payment,; for appointment reminders; for massage therapy related benefits and services; as required by law; to rule out contraindications and to ensure safety for massage practices; to perform and evaluate cases involving the effects of massage on people with certain conditions; to gain more experience with massage in certain conditions.

Generally, Who Has Access To Your Information

Generally, student massage therapists, massage therapists, and the clinical supervisor have immediate access to your health information. The program coordinator also has immediate access. Other individuals that may have access may be the school director or front desk personnel. All other school staff, clients and personnel do not have access to your medical records.

Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you: Right to amend; right to inspect and copy; right to an accounting of disclosures; right to request restrictions; right to request confidential communications; right to a paper copy of this notice both in summary and in complete version.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services. To file a complaint with our student massage clinic, please contact our Privacy Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide permission for us to use or disclose medical information about you, you may revoke your permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care we provided you.

Office Manager: Jill Cole 859-252-5656 ext. 31

Patient Acknowledgement

I read the Privacy notice and understand that I have the right to receive a copy. I also understand that a request for a copy should be made to the massage clinical supervisor.

Signature:_____ **Date:**_____

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Cancellation Policy

When an appointment is made, a certain amount of time is reserved for just you! We do what we can to be here when you need us, and we kindly ask that you be here when expected. Due to numerous missed appointments, we have established the following:

The Lexington Healing Arts Academy has instituted a policy in order to reduce the number of no-show or missed appointments. We require a 24hour notice for cancellation of any appointment that you will not be able to attend. If the notice is not given, you will be billed for the full amount of the session and unable to reschedule until this bill has been paid in full. Although we do our best to call or email the day prior to your appointment, this is only done as a courtesy and not to be considered a confirmation. Your appointment is considered confirmed the moment you make it.

Thank you for understanding.

I have been made aware that 24 hour notice must be given in order to cancel any appointment. If this notice is not given, I agree to pay the full amount and/or cost of the services for the time which was allotted for me.

_____
Client Signature

_____
Date

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Personal Property

Lexington Healing Arts is not responsible for personal items brought with you into the treatment room. Although we have a very safe and secure environment, we cannot be responsible for loss or damage to your personal possessions.

Please remove all jewelry before your massage.

If items are lost and we find them they will be kept in our "Lost and Found" at the Front Desk.

Thank you for understanding.

Client Acknowledgement

I have read the Personal Property Notice and understand that LHAA cannot be held responsible for my personal property.

_____
Client Signature

_____
Date