Pure Serenity
Health Spa

440 Columbia Blvd., Saint Helens, Oregon 97051 | 503-366-8084

Client Agreement Form

-Please Initial Each Item Below-

1._____ I am aware treatments may use extreme temperatures that can be modified. I understand that it is my responsibility to communicate any discomfort caused by the temperature or the pressure during the treatment.

2._____I agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Pure Serenity Massage, LLC

3._____I am aware that when I pay for my treatment ON THE SAME DAY OF SERVICE my price is at a discounted rate. If Pure Serenity Massage LLC is billing your insurance or billing client at a later date then the rate of $48.95 per 15 minute unit is billed.

4._____If this account is assigned to an attorney for collections and or suit, the prevailing party shall be entitled to attorney's fees and cost of collections.

5._____I authorize release of my information to third parties (lawyer & collections) requiring these records for determination of financial liability, if I have not paid for the service rendered.

6._____ I understand that Massage Therapy is here for the purpose of stress reduction, relief of muscular tension, spasms, or for increasing circulation and energy flow.

7._____ I understand that Massage Therapists do not diagnose illness, disease, or any other physical conditions. I have stated all my known medical conditions and take it upon myself to keep the massage therapist informed of any changes.

8._____ I understand that Pure Serenity Massage LLC has the right to refuse service to anyone. I agree that if a therapist feels, for any reason, that they need to end your treatment early that they have the right to do so.

9._____I understand that our time together is precious. I agree to cancel 6 hours in advance for my appointment. If I am a no show without a call in to cancel I agree to pay ½ of the appointment fee. I agree that my credit card on file will be used to cover the late fee THE DAY OF the missed appointment.

10._____I understand that bounced/returned checks will result in a $30 fee, plus the cost of the treatment.

11._____ I understand that if I am late to my appointment the therapists will end at the initial agreed upon time and a prorated price will not be accommodated.

By signing this application, I affirm, I have given true, complete information.

Date_____ Signature_____

Printed Name_____

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Client Intake Form

Date_____

Name_____ Email:_____

Would you like to receive emails from us about our openings and promotions? (circle) Yes or No

Address_____ City_____ Zip_____

CHECK preferred number you would like us to use **first** for confirmation calls:

☐ Home#_____ ☐ Cell#_____ ☐ Work:#_____

DOB _____ Employer_____ Occupation_____

Emergency Contact Name_____ Phone Number_____

Have you ever received a professional massage? Y___N___

How long has it been since your last professional massage?

Are you on any medications (vitamins, herbs or pharmaceuticals)? Please List.

Describe any surgeries, accidents or injuries you have had in the last 5 years.

Do you have any ongoing, chronic pain or discomfort? Where?

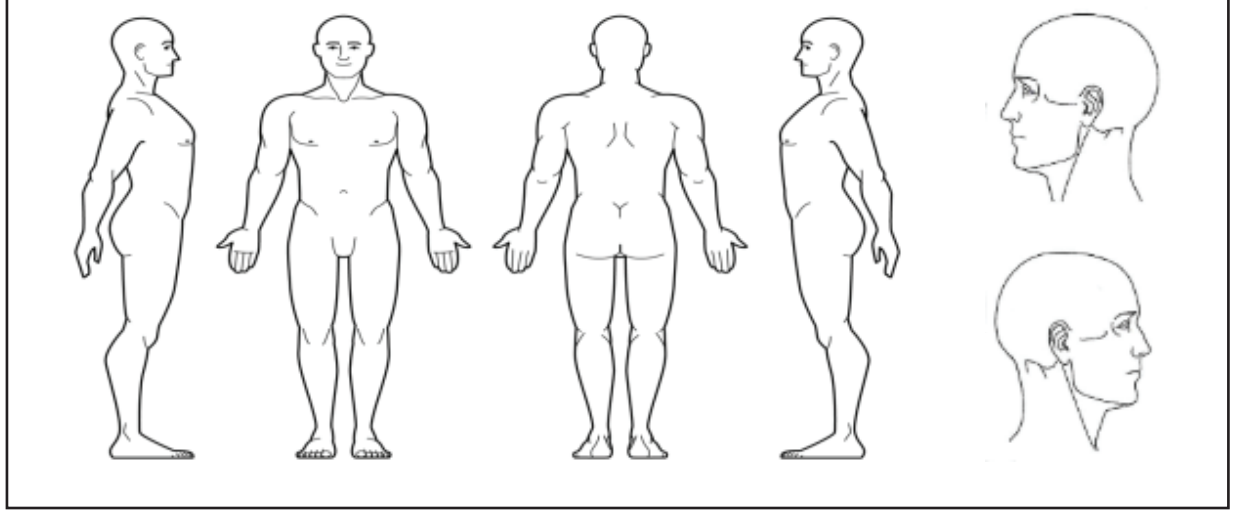
Are you receiving any other type of medical treatment that I need to be aware of? Y___N___

Are you allergic to any seafood, peanuts, oils, lotions, herbs, and essential oils? Y__N__
If yes, please list:

HIPPA Notice of Privacy Practices: Attached to this clipboard is our notice of privacy practices. Please read it over and sign and date this page acknowledging that you have reviewed and understand the practices.

Clients Signature:_____ Date_____

Please shade in the areas you experience pain



Are you currently experiencing any of the following conditions?

___Flu / Cold ___Inflammation ___Fever ___Infection

-Please check any of the following conditions that currently affect you-

Musculoskeletal

_Fibromyalgia
_Spasms/Cramps
_Sprains/Strains
_Osteoporosis
_Arthritis
_TMJ
_Tendinitis
_Diabetes
_Ear Infection
_Whiplash
_Carpal Tunnel Syndrome
_Sciatica
_Thoracic Outlet Syndrome
_Other

Respiratory

_Sinusitis
_Asthma
_Trouble Breathing
_Dizziness
_Other

Circulatory

_Anemia
_High Blood Pressure
_Low Blood Pressure
_Varicose Veins
_Heart Condition
_Blood Clots/Phlebitis
_Diabetes

Skin

_Fungal Infection
_Impetigo
_Dermatitis/Eczema
_Psoriasis
_Open Wound or sores
_Rashes
_Athletes Foot

Nervous System

_Multiple Sclerosis
_Parkinson's Disease
_Neuritis
_Spinal Cord Injury
_Stroke
_Seizure Disorders
_Numbness/Tingling

Digestive

_Ulcers
_Hepatitis
_Gas/bloating

Other

_Ear Infection
_Vertigo
_Insomnia
_Anxiety/ Panic Attacks
_PMS
_Grief Process
_Cancer
_Substance Abuse
_Pregnancy
_Chronic Fatigue
_Lupus
_Kidney Disease
_Edema
_Depression
_Other

The above information is accurate and true to the best of my knowledge. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Signature_____Date_____