



Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

**MUSCULOSKELETAL CONDITIONS:** Place an X in the appropriate box, if you are experiencing any of the following:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Ankle Pain                  | <input type="checkbox"/> Foot Pain       | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Back Pain                   | <input type="checkbox"/> Hand/Wrist Pain | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> Body Aches                  | <input type="checkbox"/> Hip Pain        | <input type="checkbox"/> Shoulder Pain   |
| <input type="checkbox"/> Bruise Easily               | <input type="checkbox"/> Knee Pain       | <input type="checkbox"/> Swelling        |
| <input type="checkbox"/> Difficulty Standing/Walking | <input type="checkbox"/> Muscle Spasm    | <input type="checkbox"/> Radiating Pain  |

What is your main musculoskeletal complaint & when did this condition begin? \_\_\_\_\_

How frequent and for how long do you experience pain? \_\_\_\_\_

Does your pain limit your daily or recreational activities in any way? \_\_\_\_\_

What is the intensity of the pain from a scale of 1-10?    1    2    3    4    5    6    7    8    9    10

What is the quality of your pain? Mark any that apply.

- |                                  |  |   |
|----------------------------------|--|---|
| <input type="checkbox"/> Achy    | <input type="checkbox"/> Electric          | <input type="checkbox"/> Pins & Needles |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Loss of Sensation | <input type="checkbox"/> Sharp          |
| <input type="checkbox"/> Dull    | <input type="checkbox"/> Numb              |   |

Please describe any exercise routine. \_\_\_\_\_

Please rate your overall stress level on a scale of 1-10: \_\_\_\_\_

**HEALTH HISTORY:** Please complete the following health history chart for yourself by placing an X in the appropriate box.

CONDITION	X	CONDITION	X
Allergies		Headaches/Migraines	
Arthritis		High Blood Pressure	
Asthma		Joint Swelling	
Broken Bone or Fracture		Multiple Sclerosis	
Cancer or Tumors		Osteoporosis	
Chronic Fatigue Syndrome		Parkinson's Disease	
Diabetes		Significant Trauma/Injury	
Fibromyalgia		Seizures/Epilepsy	
Gastrointestinal Disorder		Varicose Veins	
Heart Disease		Other (Please Specify)	
Current Skin Conditions – Circle all that apply: acne, abrasions/cuts, birthmarks/moles, bruises, dermatitis, eczema, herpes, hives, poison ivy/oak, psoriasis, skin tags, sunburns, warts, others(please describe)		Surgery: Date: Describe:	

Are you currently pregnant?    Yes    No    If Yes, how many weeks? \_\_\_\_\_    Are you currently nursing?    Yes    No

Is this a high risk pregnancy?    Yes    No    Please explain: \_\_\_\_\_

Signature of client or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OMBE** Integrative Health Center    551 Boylston Street, 4<sup>th</sup> Floor    Boston, MA 02116    617.447.2222    www.ombecenter.com

## MESSAGE INFORMED CONSENT

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation or relieve of muscular tension. 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 further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage 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 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.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of massage and other treatments, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

### MASSAGES PACKAGES & 24-HOUR CANCELLATION POLICY

The fee structure for massage packages reduces the price of each session and is paid in advance to the facility. I realize that should I purchase such a package, there is no refund or credit should I not use all sessions included in this package. I am aware of and accept these policies noted above. I understand that if I schedule an appointment for a massage session, I will be responsible for the full charge of the massage session should I need to cancel and do not provide a 24-hour notice prior to the scheduled appointment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## OMBE Privacy Policies Notice

This notice describes how your medical information may be used and disclosed, how you can access this information, and how your privacy is being protected at OMBE. OMBE, all health care providers at OMBE, and all associates providing service at OMBE are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information. The privacy of your medical records is important to us and we are committed to protecting your medical records. We create a record of the services you receive at OMBE in a paper chart and on a computer. We need this record to provide you with quality care and to comply with certain legal requirements. In order to maintain the service level that you expect from a health care office, we may need to share limited personal medical and financial information. Your medical records are the property of this health care office, but the information in the medical record belongs to you. This notice also describes your rights and certain duties we have regarding the use and disclosure of medical information.

### ***How OMBE May Use or Disclose Your Health Information***

**Treatment:** We use medical information about you to provide your health care. We may disclose your health care information to other health care providers within our practice for the purpose of treatment, payment or health care operations. On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with OMBE. We may share your medical information with other physicians or other health care providers who will provide services that we do not provide. We may share this information with a physician who will need to treat you, or a laboratory that performs a test.

**Payment:** We use and disclose medical information about you to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you. For example, we may disclose your health information to your insurance provider or a third party for the purpose of payment, to receive prior approval, or to determine whether your plan will cover the treatment.

**Workers' Compensation:** We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

**Health Care Operations:** We may use and disclose medical information about you to operate this health care practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence, and qualifications of our staff. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud detection and compliance programs. We may also share your medical information with our "business associates", such as our appointment scheduling and billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. Additionally, the health care practice has an open waiting room where patients may be seen by other patients. The secure area around the front desk also has a computer and fax machine that may be visible to the public. This area is limited to OMBE staff and health care providers only and the computer has an automatic screen saver that is activated after two minutes without activity.

**Appointment Reminders:** We may contact you for appointment reminders. If you are not available, we may leave a message via email, a voicemail inbox, answering machine, or with the person answering your home phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

**Notification and Communication with Family:** We may disclose your health information to notify a family member or another person responsible for your care about your location and general condition in the event you are sick or injured. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. We may disclose this information in an emergency situation.

**Marketing:** We may contact you to give you information about products or services, case management, care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We do not disclose your personal contact information including your phone number or email address to any third party for marketing or solicitation.

**Required by Law:** When the law requires us to report abuse, neglect, domestic violence, we will comply with the relevant legal requirements. We may, and are sometimes required by local, state, or federal law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may disclose your

health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

**Public Health & Safety:** We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury, or disability; reporting child, elder, or dependent adult abuse or neglect; and reporting domestic violence. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

**Special Government Functions:** If you are a member of the armed forces, we may release protected health information about you if it relates to military and veteran activities. We may also release your protected health information for national security purposes, protective services for the President, and medical suitability or determinations of the Department of State.

**Deceased Persons:** We may disclose your health information to coroners, medical examiners, funeral directors, or organizations involved in procuring, banking, or transplanting tissues.

**Change of Ownership:** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

**Right to Request Special Privacy Protections:** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit in our use or disclosure. We reserve the right to accept or reject your request, and will notify you of our decision.

**Right to Request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable communication requests submitted in writing.

**Right to Inspect and Copy:** You have the right to inspect and copy your health information. To access your health information, submit a written request detailing the information you want access, inspect, or copy. We will charge a reasonable fee, as allowed by federal law. We may deny your request under limited circumstances. You have the right to appeal our decision if we deny access your child's records in the case that access could cause harm to your child.

**Right to Amend or Supplement:** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about OMBE's denial and how you can disagree with the denial within thirty (30) days of receipt of your written request. We may deny your request if we do not have the information, if we did not create the information, if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

**Right to an Accounting of Disclosures:** You have a right to receive an accounting of disclosures of your health information made by this office, except that this office does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in the Treatment, Payment, Health Care Operations, Notification and Communication with Family paragraphs. Additionally, this office does not have to account for disclosures otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this office has received notice from that agency or official that providing this accounting would be likely to impede their activities.

### ***More About OMBE's Privacy Policy***

We reserve the right to amend this Privacy Policies Notice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice will apply to all protected health information that we maintain. You have the right to request a current copy of this Notice which is maintained on our website and at the front desk. If you would like a more detailed explanation of these rights, to exercise one or more of these rights, or submit any complaints in regards to this Notice, please contact our Privacy Officer, Jessica Molleur. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint without the risk of penalization to: Department of Health and Human Services, Office of Civil Rights, Hubert H. Humphrey Bldg., 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

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## OMBE Privacy Policies Acknowledgement

I have received, read, and understood OMBE's Privacy Policies Notice. I understand how this health care office and its health care providers may use or disclose my health information. I understand when this health care office may not use or disclose my health information. I understand my health information rights and understand that the office reserves the right to change the Privacy Policies Notice. I also understand how to place a complaint regarding this Notice and have also been provided the opportunity to review and question the privacy policies of this health care office.

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Signature of Patient or Authorizes Representative

Date