Whole Body Wellness
Medical and Sports Massage

RELEASE OF INFORMATION AUTHORIZATION

Name_____ **Today's Date**_____

Mailing Address_____ **City**_____

State_____ **Zip**_____ **Date of Birth**_____

Phone_____ **Email**_____

I authorize Whole Body Wellness, LLC to release all medical records or other Protected Health Information (PHI) including: Intake Forms, Chart Notes, Reports, Correspondence ,Billing Statements and other written information concerning my health and treatment as requested by my health insurance carrier or any other third party payers.

I authorize Whole Body Wellness, LLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning overage and payment under my policy. I direct the insurance company or health plan administrator to release such information to Whole Body Wellness, LLC.

I also authorize the release of my medical records tor other PHI concerning my health and treatment during the period of _____ to _____ to be sent to the following person or company:

Name_____ **Company**_____

Mailing Address_____ **City**_____

State_____ **Zip**_____ **Phone**_____ **Email**_____

I agree that these provisions remain in effect until I provide written revocation to Whole Body Wellness, LLC.

Patient's Name (printed) _____

_____
Responsible Party

_____
Relationship to Patient

_____ _____
Signature Patient or Responsible Party date

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Informed Consent Agreement

I have had an opportunity to ask my therapist at Whole Body Wellness, LLC. questions about the symptoms presented and the clinical procedures that may be appropriate.

I, the undersigned, do hereby voluntarily consent and authorize the therapists at Whole Body Wellness, LLC to perform and/or apply one or more of the following:

- Clinical Medical Massage and Manual Therapy
- Cupping, Therapeutic Kinesiology Taping, Moist Heat Application
- Lymphatic Drainage, Hot Stone/Cold Stone Massage
- Liniments, Oils, Plasters: Herbal formulas applied topically to the skin.
- Nutritional Advice: Includes diet and herbal recommendations.

I understand that the potential benefits and risks of these procedures include:

- **Potential Benefits**: (Including but not limited to) drugless relief of presenting symptoms and improved sensation, use and motion that may lead to the prevention, improvement or elimination of the presenting problem.

- **Potential Risks**: (Including but not limited to) discomfort, pain, bruising, blistering, temporary discoloration of the skin, possible aggravation of symptoms existing prior to the treatment.

NOTE: Patients with bleeding disorders or pacemakers, as well as pregnant patients, should inform their practitioner prior to treatment.

I understand there are no guarantees that these procedures will cure or improve my condition.

In order for Whole Body Wellness, LLC to perform these procedures, I release them from any and all liability that may occur in connection with my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Jennifer Fowler, lead therapist Whole Body Wellness, LLC NMLMT #5906

I have read and agree to the above terms:

_____
Client Name - Printed

_____ _____
Client or Parent/Guardian of minor - Signature Date

Whole Body Wellness, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your Protected Health Information for the purposes of treatment, payment and health care operations, and in certain other circumstances as required by law:

Treatment **means providing, coordinating, or managing health care and related services by one or more health care** providers.

Payment means such activities as obtaining reimbursement of services, confirming coverage, billing or collection activities, and utilization review.

Health Care Operations include the business aspects of running our practice, such as using your confidential information to remind you of an appointment, or assessing our documentation protocols, etc. In addition we would disclose your Protected Health Information when required to do so by federal, state or local law. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain right in regards to your Protected Health Information (PHI): The right to access, inspect and receive a copy of your PHI. The right to request restriction on certain uses and disclosures of PHI, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to request to receive confidential communications of PHI such as not leaving a message on a phone machine, or only contacting you at work, for example The right to request an amendment to your PHI.The right to receive an accounting of disclosures of PHI outside of the treatment, payment and health care operations. The right to obtain a paper copy of this notice from us upon request.

I have had an opportunity to read, and can received a copy, if requested, of Whole Body Wellness Notice of Privacy Practices .

Patient Name (print)_____Date_____

Signature of Patient_____ (Legal Guardian)