Terms of Service for Massage

Please initial by all numbers!

1. Payment is **due** upfront and due at time services are rendered. *Initial*
2. This is massage is **NON SEXUAL**, if asked or any suggestions of it, your massage will cancelled and your still responsible for payment *Initial*
3. Confirmed appointments require picture identification i.e.. Drivers license or passport *Initial*
4. The price is set and firm. Absolutely no negotiations. *Initial*
5. Acceptable form of payment is cash or email transfer or credit card if paying by email transfers it must be done before the start of the massage. Initial
6. Prices do not include GST. Initial
7. Direct billing is available and you **MUST PROVIDE CREDIT CARD.** *If payment is not received within 15 days of service your credit card will be charged Initial*
8. 24hr notice for cancellation. All cancellations must be made by email.
9. A case history form must be completed. Initial
10. All receipts will be given electronically. A registered massage therapist will provide massage. Receipts will be issued and reimbursement from the insurance company is the responsibility of client to submit. Please provide email. Initial
11. Receipts are issued in the name of person receiving massage.
12. Clients are expected to be ready and on time upon arrival for massage services. *Initial*
13. There is a 10-minute late policy. If you more than 10 minutes late for your appointment, it will be cancelled. If you book future appointments there will be a half an hr charge added. Initial
14. If a deal is made for multiple people the price goes for all parties. If only **one** person receives massage then it's the regular price. Initial
15. Prices may change without notice. Initial
16. Reserve the right refuses service. Initial

Signature:	Date:	Email:

Alberta health Care Card	**Drivers License**	**Benefit Card**

J. Willa Healing & Mobile Intake Form

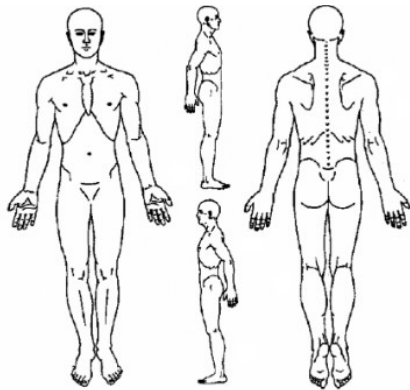
Name: Birth date: ___Male ___Female
Address: City: Postal code:
Email: Occupation: How did you hear about us:
Emergency Contact: Telephone numbers:

A) For what reason(s) have you made this appointment? (i.e. pain, stress, relaxation, injury etc)

B) Have you received Professional Massage Therapy before?
If YES, how long ago and for what reason(s)

C) Have you had any serious or chronic illness, operations, or traumatic accidents?

D) Are you on any medication? IF YES, which ones:



Please check off any of the following conditions or symptoms that apply to you now or in the past. If none of these are applicable please **initial**.

__ Contagious Conditions
__ High_ Low Blood Pressure
__ Back Pain
__ Allergies
__ Osteoporosis
__ Headaches
__Diabetes
__ Surgical Implants
__ Pregnant
__ Blood Clots
__ Varicose Veins
__Bursitis
__ Skin Infections
__ Hypo-Hyperglycemia
__ Muscle Pain/Strain
__ Heart Attack/Stroke
__ Arthritis

I have completed this health form to the best of my knowledge. I understand that any Massage Therapy Services provided by my Massage Therapist does not take the place of a physician's care.

Please take a moment to read and **initial** all of the following statements:

- If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.
- I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.
- I affirm that I have notified my therapist of all known medical conditions and injuries.
- I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.
- I understand that massage is entirely therapeutic and non-sexual in nature.

By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to

massage therapy and bodywork.

Date: Signature

Electronic Transmission Authorization and Consent Form 1

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: ____
Address: ____
City/Province: _____________________________________
Postal Code: _______________________________________
Phone Number: _____________________________________
Patient: ____
Address: ____
City/Province: ______________________________________
Postal Code: ____
Phone Number: ______________________________________
Plan Number: ____
Certificate / Plan member Number: ____________________

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:
use my personal information for the above purposes.

exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.

exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Electronic Transmission Authorization and Consent Form 2

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

________________________ ___________________________

Date: Signature

Print Name