Vital Life Massage LLC

COMPLIMENTARY & ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

Practitioner Name: Lisa Donth

Business Name: Vital Life Massage LLC

Business Address: 1051 Madison Avenue, Suite 1, Mankato, MN 56001

Telephone number: 507/420-4654

As of July 1, 2001, Minnesota's Freedom of Access to Complementary Care Law (Statute Chapter 146A) requires that you receive and acknowledge that you have received by your signature on the back of this page, the following information prior to your treatment.

Lisa Donth, hereafter, "the Practitioner" has the received following education, training & credentials:
Associates of Applied Science Degree in Massage Therapy – Rasmussen College
NCTMB – Nationally Certified in Therapeutic Massage and Bodywork
BCTMB – Board Certified in Therapeutic Massage and Bodywork
Migraine Miracle® - Kelly Lott
Secrets of Deep Tissue – Haase Myotherapy
Massage for Fibromyalgia – Nirvana Massage
Skin Health – The World Skin Project
Professional Ethics and the Art of Relationship – AMTA

The Information that follows in quotation marks is required to be on the Client Bill of Rights in bold print by the state statute: **"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATION PURPOSES ONLY. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time."**

- **Complaints:** If the Client has a complaint or concern about the care or services they have received, the Client may also contact the Office of Unlicensed Complementary and Alternative Health Care Practice located in Minnesota Department of Health: **Mailing address:** P.O. Box 64882, St. Paul, MN 55164-0882 **Phone:** 651-201-3728 **Fax:** 651-201-3839 **Website:** www.health.state.mn.us **E-mail:** richard.hnasko@state.mn.us

- **Fees, Payment, Insurance:** Fees for Massage Therapy at the Practitioner's office are as follows, with all taxes included: $30 for 30 minutes, $45 for 45 minutes, $58 for 60 minutes, or $85 for 90 minutes. Payment is accepted by cash, check, or Credit Card. This Practitioner is not under contract with any HMO, PPO, or any other Insurance Company to provide discounted services. This Practitioner does not directly accept Medicare, Medical Assistance, or general assistance medical care. Payment in full for services is expected at the time of service, unless otherwise arranged prior to the appointment. Vital Life Massage requests 24 hours notice for cancellations to avoid billing of missed appointment.

• **Change of Price:** Clients have the right to reasonable notice of changes to the prices, services, or policies. Changes in session fees, services, or policies will be provided by being posted in the Practitioner's office, being on the Practitioner's website, or by the client asking when scheduling the appointment**.**

• **Theory of Treatment:** The state requires a "Plain language" summary of the "theoretical approach used to provide service to clients". It is this Practitioner's approach to complete a pre-treatment evaluation at every visit ensuring that both new and on-going muscular dysfunctions will be addressed. All treatment plans will be clearly explained to the client prior to the beginning of each session and will be performed using the appropriate modality for the muscular issues being addressed.

• **Right to Current Information:** Clients have the right to complete and current information concerning the practitioner's assessment and recommended service that is to be provided, including the expected duration of the service to be provided.

• **Right to Confidentiality:** Client records are confidential and will not be released, unless authorized by the client in writing or as otherwise provided for by law.

• **Right to Self Access:** Clients have the right to access their own records maintained by the Practitioner's office, in accordance with state statute sections 144.291 to 144.298.

• **Personal Interaction:** Clients have the right to expect courteous treatment, free from verbal, physical, or sexual abuse.

• **Other Treatment Available:** Other massage therapy services are available to the Client in this same community. These can be located by asking the Practitioner, the provider who referred you to this practitioner, or the following practitioner database: www.amtamassage.org.

• **Right of Agency:** The Client has the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

• **Records Transfer:** The Client has the right to coordinated transfer of their records when there will be a change in the provider of services.

• **Right of Refusal:** The Client may refuse services or treatment, unless otherwise provided by law.

• **Right of Nonretribution:** The Client has the right to assert any and all of above-mentioned rights without retaliation from the Practitioner.

I _____acknowledge by my signature that I have received and understand the Complementary and Alternative Health Care Client Bill of Rights.

Signature_____Date_____

Vital Life Massage LLC

MEDICAL INTAKE AND RELEASE FORM

Please Complete Both Sides

Name _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Email _____

Address _____ City _____ State _____ Zip _____

Occupation _____

Emergency Contact/Relationship _____ Telephone _____

If answering "Yes" to any of the following questions, please explain in the space provided.

Are you taking any medication (including non-prescription)? Yes No

Do you bruise easily? Yes No

Do you suffer from heart disease? Yes No

Do you suffer from allergies? Yes No

Do you have diabetes? Yes No

Do you suffer from arthritis? Yes No

Do you suffer from asthma? Yes No

Do you suffer from high blood pressure? Yes No

Do you have any blood disorder? Yes No

Do you suffer from epilepsy or seizures? Yes No

Do you suffer from any skin ailments? Yes No

Do you suffer from claustrophobia? Yes No

Are you pregnant or nursing? Yes No

Do you have any contagious disease? Yes No

Do you wear contact lenses? Yes No

Do you have varicose or spider veins? Yes No

Have you ever had surgery? Yes No

Do you wear a pacemaker? Yes No

Do you have any herniated disks? Yes No

Do you suffer from chronic back pain? Yes No

Do you suffer from stress? Yes No

Are you wearing any patches? Yes No

Have you ever had or are you currently being treated for cancer? Yes No

Are you currently being treated by a physician for any condition? Yes No

Do you have any medical condition I should know about? Yes No

When was your last massage? _____

Details from questions:_____

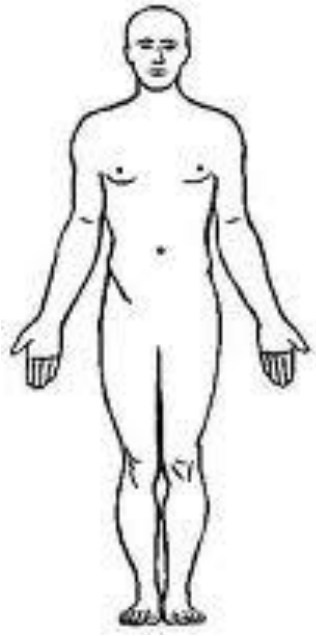
_____

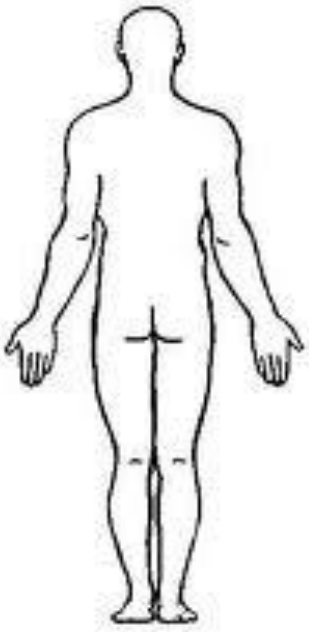
_____

_____

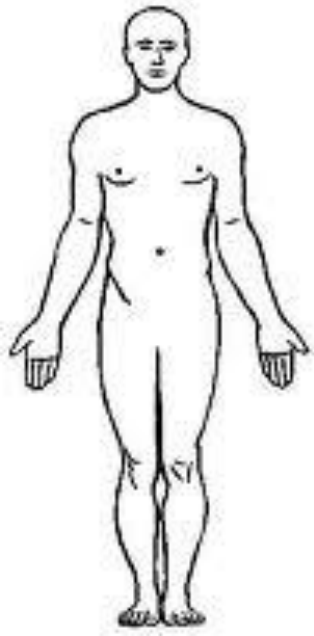
Mark Stress Zones

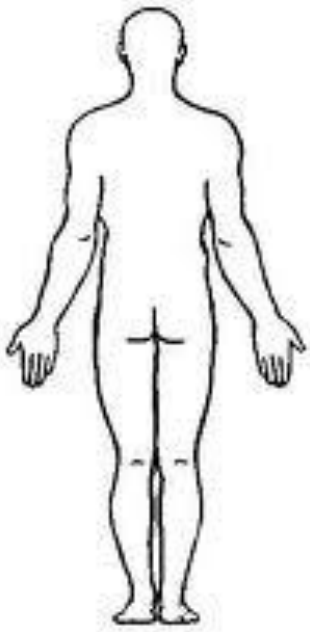
(Please circle the area of discomfort)





Mark Areas You Do NOT wish treated





Informed consent: the above information is accurate to the best of my knowledge and I freely give my permission to be massaged. I agree to inform the therapist of any experience of pain during the session. I understand that this is not a medical treatment and that this is not a substitute for medical diagnosis, treatment, or examination. I understand that no inappropriate comments or conduct will be tolerated and that any indication of such will automatically end the session. I further understand that massage will be administered at the discretion of the therapist and any medical condition contraindicated to massage will be dealt with appropriately or the entire session will be terminated as warranted by the individual condition.

_____

Client Signature Date

_____

Therapist Signature Date