Ageless in the Triad

Massage/Bodywork Intake

Thank you for choosing Ageless in the Triad for your Body Treatments.
Please answer the following questions so that our Therapists
may better understand your goals for the treatment.

Name_____Phone_____Date of Birth_____

Address_____Age_____

City_____State_____Zip Code _____

Emergency Contact/Relationship_____Phone_____

Email_____Occupation_____

Referred by_____How did you hear about us? _____

Have you ever had a professional massage/body treatment before? _____If yes, when_____

Do you have any allergies to lotions, gels, oils or creams? _____

Are there any particular areas of the body where you are experiencing tension, stiffness, pain or discomfort?

_____

What pressure do you think you would be interested in? _____

Are there areas that you do NOT want massaged? _____

Do you bruise easily or take blood thinners? _____

Are you pregnant/nursing? _____

What are your goals for this session? _____

Health History

(Mark all that apply)

___Thyroid Disorders	___Lymph Edema	___High/Low Blood Pressure	___Chronic Pain
___Numbness/Tingling	___Sinus Problem	___Allergies	___Blood Clots
___Rashes/Bruises/Cuts	___Varicose Veins	___Jaw Pain/TMJ	___Sprains/strains
___Constipation	___Diabetes	___Gas/Bloating	___Spasm/Cramps
___Headaches	___Arthritis	___Cancer	___Cold Sores/Herpes
___Broken Bones	___Depression	___Anxiety	___Asthma
___Back Pain	___HIV/AIDS	___Hepatitis	___Pregnancy

___Digestive Issues ___Hernia ___Heart Condition/Pacemaker ___ Seizures ___Muscular Dystrophy

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I also understand that some conditions may require more than one treatment and home care may be needed to achieve the results desired. I hereby release Ageless in the Triad from any liability pertaining to treatments; understand that results cannot be guaranteed due to individual skin type(s) and conditions.

Cancellation Policy

As a courtesy to our spa professionals, please provide a minimum of 24 hours' notice should you need to cancel or reschedule an appointment. There will be a charge of 50% of scheduled services for cancellations of less than 24 hours' notice. If you have a series, one service from this series will be deducted. For filler appointments, a $100 deposit will be taken when scheduling the appointment and will be applied toward the filler service. However, if you fail to show for your appointment, we hold the right to keep the deposit. By scheduling an appointment, you are agreeing to our cancellation policy. Cancellations for Monday appointments are required to be cancelled by Friday at 4PM. When booking an appointment, a credit card will be needed to hold the appointment. We take Visa, MasterCard, Discover, American Express and Care Credit. We thank you for your understanding.

Late Policy

Your appointment time is reserved exclusively for you! If your arrival time is 15 minutes or later than your scheduled appointment, this may result in a shortened appointment. We reserve the right to reschedule your appointment.

No Show Policy

There will be a charge of 50% of scheduled services. If you have a series; one service from this series will be deducted. If you have a gift card, the amount will be deducted from the gift card.

For Botox/Dysport patients, a $50 fee will be charged to your credit card for missed appointments or reoccurring late cancellations.

Payments/Refunds

Payments for all procedures at Ageless in the Triad are due at the time of service and are non-refundable. All sales are final. However, Ageless in the Triad does have an exchange policy that gives you options if the need arises. Should you wish to discontinue your treatments in the midst of a series, you will receive pro-rated credit for the unused treatments. The treatments that have already been provided will be charged at current single treatment prices to calculate the remaining credit. This credit may be used to purchase other treatments, not products, offered at Ageless in the Triad.

Client Signature _____ Date _____

Review By_____Date_____

Patient Communication Directive with Individuals Involved in Your Care

PATIENT IDENTIFICATION

NAME: _____

DATE OF BIRTH: _____

Please list all individuals who may be involved in coordinating your care, payment of your care, or to whom we may provide the details of your care.

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____

NOTE: We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify us if you wish to alter the designations above.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and know that my treatment will not be conditioned on signing.

Signature of Patient/
Legal Representative: _____ Date: _____

Relationship to Patient: _____

To revoke this authorization, please send a written request to:

Practice Manager
Ageless in the Triad, PC
900 Old Winston Road, Suite 204B
Kernersville, NC 27284