What to Expect and Do for your Up Coming Appointment

- Call/Text to schedule Appointment (online booking is suspended until further notice)

- If any type of sickness occurs or you are just not feeling well, PLEASE RESCHEDULE YOUR APPOINTMENT (refer to New Policies)

- PLEASE HAVE A MASK ON, if you Need a Mask let your therapist know and she will have one for you at the door. You will be charged $3

- Therapist will meet you in lobby area by the Temperature/Screening Table

- Your Temperature will be taken, and COVID-19 screening questions asked

- If you have a fever of 100*F or higher; You WILL be asked to reschedule

- If you have or you recently had any chills, muscle aches, loss of smell, or new rashes or lesions; you WILL be asked to reschedule

- IF you have been around anyone that has been diagnosed in the last 14 Days or has had Coronavirus type symptoms; you WILL be asked to Reschedule

- Once Cleared you may enter the Massage Room

- You will be given Covid-19 consent forms and New Policies to sign before treatment.

- Before session begins Therapist will verbally go over what will happen during your session and after session (What to do with Masks when you are face down, etc.)

Consent for Treatment

To proceed with receiving care, I confirm and understand the following (Initial in all places provided)

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious. _____

I understand that I am the decision maker for my health care. To the best of their ability, my practitioner will provide me with information to assist me in making informed choices. This process is often referred to as “informed consent” and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Client Signature: _____ Date: _____

Parent or Guardian Signature (in case of a minor): _____ Date: _____

Client Information: Please Print

Client Name: _____ Date: _____ Date of Birth: _____

Please be advised of the policies for this office. Your signature below signifies acceptance of these policies.

Cancellation and No Shows

With all the new procedures and protocols mandated by NYS due to COVID-19, my overhead has increased while my actual work hours have decreased. I have no choice but to implement my cancellation policy. Available appointment times have had to be reduced due to the time involved to carry out the new cleaning/sanitizing procedures.

I understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. I just ask that you give at least 24 hours' notice. This will give me time to fill the appointment time slot. If less than 24 hours' notice is given and I am unable to fill the slot, you will be charged 50% of your scheduled service the first time and 100% for any late cancelations after. The charge will be added to your credit card on file or paid at the time of your next visit.

Tardiness

Due to the new extensive cleaning/sanitizing protocol, appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please be on time to your appointment.

Sickness

If you are not feeling well or have been around someone who is not feeling well, whether it is COVID related or not, please cancel your appointment as soon as you are aware of any symptoms. If it is less than the required 24-hour notice period, the cancellation fee will be waived. Please note that if this happens repeatedly you may be charged.

COVID-19

If you contract the COVID-19 virus you must wait 14 days after recovering before scheduling your next appointment. Any future appointments on the schedule will be cancelled for that time frame.

No-Fault Financial Responsibility

Once your insurance is verified, we will bill and accept payment from your insurance company for covered services. In the event that the insurance company denies payment or makes partial payment, you are responsible for the balance. Your signature below confirms your financial responsibility for all services regardless of insurance reimbursement.

Assignment of Benefits

Your signature below is confirmation that you have read, understand and adhere to the policies of this office.

Release of Medical Records

Your signature below authorizes the release of all of your medical records on file in this office, for the purpose of processing your claims, to the following: your attorney, the healthcare providers attending to this condition, and the insurance case managers. Medical records will not be edited unless otherwise stated in an exclusive release of medical records signed through your attorney.

Signature: _____ Date: _____