172 W. Carmel Drive Carmel, IN 46032 Tel: (317)575-2737

INDY LASER CLIENT INFORMATION
Myofascial Release Packet

Client Name_____

Address_____

City_____ Zip Code _____

Mobile Phone_____ Home Phone_____

Date of Birth_____ Gender_____

Emergency Contact Name_____ Phone Number_____

Primary Physician Name _____ Phone Number_____

Email Address _____

Referral Source (Circle) - Sign – Money Mailer – Web Search – Miss Indiana – Pacers – Colts – Angie's List - Facebook – Twitter – Yelp – Radio - Friend/Family – Other

If Friend or Other, please specify_____

If Web Search, which did you use? – Google – Yahoo – Bing - Other

What service(s) are you interested in? (Circle)

Hair Removal - Tattoo Removal - Skin Tightening - Age/Sun Spots - Acne Scarring
Rosacea - Stretch Marks - DermaSweep - Microdermabrasion - Chemical Peels
Body Sculpting - Myofascial Release - Therapeutic Massage - Other

Area(s) to be treated_____

How are you currently treating the area? _____

Patient Signature_____Date_____

INDY LASER MEDICAL HISTORY AND PHYSICAL

Client Name_____

Date_____

How long have you been experiencing your current condition?_____

_____

Have you had any injuries or surgeries that may affect today's treatment? _____

_____

Medications □ None _____

_____

_____

Allergies □ None _____

_____

Carefully review the following conditions and mark any you have currently, or have had in the past:

□ Pain/Stiffness	□ Pressure Sensitivity	□ Pacemaker	□ Seizures
□ Numbness/Tingling	□ Swelling	□ Poor healing	□ Herpes
□ H/L Blood Pressure	□ Varicose Veins	□ Asthma	□ Thyroid Disorders
□ Blood Clots	□ Medical Implants	□ Pregnant	□ HIV
□ Arthritis	□ Aneurysm	□ Osteoporosis	□ Neurological Disorders
□ Scoliosis	□ Stroke	□ Heart Attack	□ Cancer
□ Vertigo/Dizziness	□ Headache	□ Migraines	□ Digestive Conditions
□ Degenerative Discs	□ Broken Bones	□ Diabetes	□ Depression
□ Immunosuppression	□ Kidney Disease	□ Anxiety	□ None

Comments:

_____

_____

If information in medical or physical history were to change during course of treatments, please advise practitioner prior to continuing treatments.

Patient Signature_____**Date**_____

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INDY LASER MYOFASCIAL RELEASE THERAPY CONSENT FORM

I understand that Myofascial Release should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner's part if I fail to do so.

If I experience any pain or discomfort during the session(s), I will immediately inform the practitioner so that the pressure and/or technique may be adjusted to my level of comfort.

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, the authorities will be notified, and I will be liable for the payment of the scheduled appointment.

I certify that I have read the above consent and I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I hereby consent to the Myofascial Release Therapeutic Massage procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

Client's Name (Please Print):_____

Client's Signature:_____

Date:_____ Time:_____

Version 9/14

Name_____
(Please Print)

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION
(HIPAA)

I authorize Indy Laser to make email, text or phone reminders prior to my appointments at Indy Laser at the contact information provided to Indy Laser.

Sign_____Date_____

If you wish us to share any of your treatment or appointment related information please complete the section below.

This HIPAA form requests you to advise: (A) *to whom we may disclose information* (B) *the reason for disclosure,* and (C) *the information to be disclosed.* However, to further protect your right to privacy, Indy Laser *will not use or disclose* health information to family members, Doctors, Insurance Companies, Health Insurance Companies or to any other Entities *without a current written authorization at the time the information is to be released.*

Indy Laser may discuss your health and/or treatment with/will provide your information to:

A. I,_____, hereby authorize the disclosure of my health/treatment information from my records to:
   Name: _____
   Address: _____
   City/State/Zip: _____

B. The purpose/reason for this disclosure is:_____
   _____

C. The information I authorize to be disclosed from my health/treatment record: (initial appropriate box(es))

_____Entire record _____Visit Notes _____Health and Physical

_____Medical list _____Problem list _____Billing

Only information related to: (specify)
_____
_____

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Indy Laser Late and Cancellation Policy

As we continue to grow and book out appointments, we have the need to adopt a new cancellation and late policy. We need to have at least 24 hours notice of the need to cancel or reschedule an appointment. There will be a $25 fee for any missed appointment, being late more than 10 minutes or more for an appointment, as well as not giving a 24 hour notice of cancellation or rescheduling. If you do show up more the 10 minutes late we may not be able to treat you. This fee will be required to be paid before any additional treatments will be performed. We understand emergencies will happen and this policy is not being enforced for extra revenue. It is being enforced because it is unfair to other clients who would like to have your unused appointment slot. A fee can be waived for an emergency and this fee can only be waived one time.

Signed: _____Date:_____
(Patient or person legally authorized to consent for patient)

Indy Laser Myofascial Release
Treatment Consent Form

I agree and confirm I have not started any new medications, or have not had any change in my medical or health condition since my last treatment. I understand that not disclosing the above information may cause complications with my treatments. I understand my practitioner has the right to refuse any service to me for any of the above reasons.

I have read and understand all the information presented to me before signing this consent. I release Indy laser and its practitioner from liability associated with the treatments I am requesting them to perform.

Signed: _________________________Date: _________ Current Phone: (___)__________Home/Cell/Work
(Patient or person legally authorized to consent for patient)

Signed: _________________________Date: _________ Current Phone: (___)__________Home/Cell/Work
(Patient or person legally authorized to consent for patient)

Signed: _________________________Date: _________ Current Phone: (___)__________Home/Cell/Work
(Patient or person legally authorized to consent for patient)

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