SUKHA
MASSAGE + YOGA

Massage Policies

- **Please read the Covid-19 Protocol on our website for updated requirements and responsibilities before your arrival.**

- Massage appointments are scheduled for one hour or more, this includes time for paperwork, interviewing and changing sheets. The better prepared you are the more hands on time will be honored.

- Please do not wear any perfume or scents for your massage, as many people have allergies or sensitivities. Deodorant is okay.

- If you are sick please use your best judgment as to whether you are contagious and can spread germs to the practitioner or others who may occupy the massage treatment room. **Please see Covid-19 Protocols on our website**

- If you cannot arrive for your appointment, you must call 24 hours ahead of time. We are waving the 24hour Cancellation fee Due to Covid-19 if you are sick in anyway. However, if you do not call or show, you will be responsible for the total cost of the appointment scheduled.

- If you are under the care of a Medical Doctor, for any reason, please notify the practitioner of your condition before you receive a massage.

- You are responsible for payment of all services rendered upon the completion of your appointment.

- It is expected that you completely disrobe for your massage. The only exposure will be the area that is being worked on. This is for comfort and efficiency throughout your massage.

- It is understood that this is a professional massage. Any touching of the Licensed Massage Therapist or yourself, acts of inappropriate behavior or conduct, your massage will cease right away. We also ask that you refrain from asking out our therapists for any kind of dates/social gatherings or connecting with them personally on Social Media.

Sign: _____ Date: _____

CONFIDENTIAL INFORMATION

Aloha and welcome to Sukha! We want to make your appointment as pleasant and comfortable as possible. If at any time you have questions regarding your therapy session, please let us know.

NAME_____ HOME# _____ WORK #_____

Address_____ City _____State _____ ZIP _____

DATE OF BIRTH _____AGE_____SEX_____GENDER _____PRONOUN _____
(OPTIONAL)

MARITAL STATUS: Married / Single /Divorced/ Life Partner

OCCUPATION _____ REFERRED BY _____

HAVE YOU RECEIVED MASSAGE THERAPY? YES _____ NO _____ IF YES, WHAT TYPE OF MASSAGE

EXPERIENCED. (I.E. DEEP TISSUE, SWEDISH, TRIGGER POINT, etc.) _____

ARE YOU TAKIN MEDICATIONS? Y / N IF SO, WHAT KIND _____

ARE YOU PREGNANT? Y / N HAVE YOU CONSUMED ALCOHOL IN THE LAST 24HOURS? Y/ N

DO YOU HAVE A HISTORY OF THE FOLLOWING?

- ☐ accident
- ☐ neck pain
- ☐ whiplash
- ☐ headache
- ☐ shoulder pain
- ☐ upper back pain
- ☐ mid back pain
- ☐ low back pain
- ☐ joint ache
- ☐ decreased range of motion
- ☐broken bones
- ☐ sciatica
- ☐ sprains
- ☐ seizures
- ☐ abdominal pain
- ☐ nervous tension
- ☐ arthritis, bursitis, tendonitis
- ☐ gout
- ☐ allergies to oil or perfumes
- ☐ plantar fasciitis
- ☐ wear contacts
- ☐ scoliosis
- ☐ fibromyalgia
- ☐ carpal tunnel syndrome
- ☐ mastectomy
- ☐ breast augmentation
- ☐ diabetes
- ☐ varicose veins
- ☐ high blood pressure
- ☐ stroke
- ☐ heart attack
- ☐ cancer
- ☐ colitis
- ☐ HIV
- ☐ _____

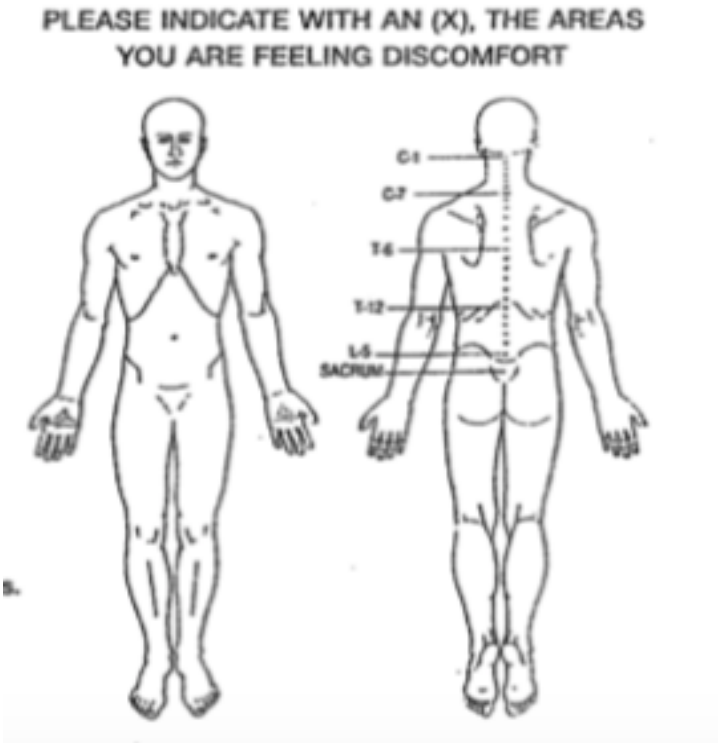
Please indicate your consumption level TODAY?

	None	Light	Moderate	Heavy
salt	☐	☐	☐	☐
sugar	☐	☐	☐	☐
caffeine	☐	☐	☐	☐
tobacco	☐	☐	☐	☐
alcohol	☐	☐	☐	☐
exercise	☐	☐	☐	☐
water	☐	☐	☐	☐

DO YOU HAVE ANY OF THE FOLLOWING

- ☐ sunburn
- ☐inflammation
- ☐ sever pain
- ☐ headache
- ☐ allergies
- ☐ open cuts, bruises, burns
- ☐ irritated skin rash
- ☐ poison ivy
- ☐ fever/cold/flu
- ☐ other _____

PLEASE INDICATE WITH AN (X), THE AREAS YOU ARE FEELING DISCOMFORT



WHATE ARE YOUR GOALS/EXPECTATIONS FOR THE MASSAGE THERAPY SESSION?

PLEASE READ THE FOLLOWING AND SIGN BELOW:

- I understand that this massage is not a replacement for medical care and that no diagnoses will be made.
- I am responsible for paying for any appointment cancellation less that 24 hours. Unless otherwise indicated for Covid-19.

_____ _____

Signature of Client or Legal Guardian/Representative Date

Health Information–COVID-19 Information & Liability Waiver

Client Name: _____ Date: _____

COVID-19 Information

1. Have you had a fever in the last 24 hours of 100°F or above? Yes ☐ No ☐
2. Do you know, or have you recently had, any respiratory or flu symptoms, sore throat, or shortness of breath? Yes ☐ No ☐
3. Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or has coronavirus-type symptoms? Yes ☐ No ☐
4. Have you traveled out of the area? (state or country in the last 2 weeks) Yes ☐ No ☐

Consent for Treatment

I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge that I am aware of the risks involved from receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless the practitioner/business from any claims related thereto. I give my consent to receive treatment from this practitioner.

Client Signature: _____ Date: _____

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

Sukha
22021 7th Ave South #3
Des Moines, WA 98198
Main: (206) 429-2782
Email: sukhahappens@gmail.com

CONSENT AND ACKNOWLEDGEMENT FORM

Sukha – Healing Arts Center
22021 7th Ave South Suite 3
Des Moines, WA 98198

I understand that with my consent, Sukha, may use and share with others my personal health information for purposes of treatment, to obtain payment for treatment services if appropriate, and for health care operations. I understand that if I do not consent, Sukha, will be limited in their ability to serve me. My information may be release to others for certain uses permitted by state and federal law. These possible uses and disclosures are described more fully in the Notice of Privacy Practices.

I understand that I have the right to have my personal health information handled in a confidential manner, housed in a secure environment, and accessed only by the authorized persons who have a need and right to know the information. I have the right to access and revoke authorization information, request corrections or restrictions, and to receive an accounting of certain disclosures.

☐ I give permission to Sukha to use my address, phone number, e-mail and clinical records to contact me with online calendar scheduling, birthday cards, holiday related cards and information about treatment alternatives or other health related information.

Email: _____

I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

_____ _____
Signature of Client or Legal Representative Date

I acknowledge that I have read the Notice of Privacy Practices that describes how my personal health information may be used or shared with others, my rights regarding to this information, and the legal obligation of Sukha.

_____ _____
Signature of Client or Legal Guardian/Representative Date

Expiration Date: The authorization shall expire on the following date: _____

Sukha – Healing Arts Center
22021 7th Ave South Suite 3
Des Moines, WA 98198

The Health Insurance Portability and Accountability Act (HIPAA)

NOTICE OF PATIENT PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you may gain access to this information.

You will be asked to sign an Acknowledgment that you have received this Notice of Patient Privacy Practices. In Accordance with the HIPAA Privacy Regulation, this Notice describes how Sukha may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. The Notice also describes your rights and the Clinic's requirements to protect your health information.

Treatment, Payment and Health Care Operations
For purposes of treatment: We will use your health care information to treat you. For example, we will use your information to help us diagnose and design a course of treatment for you. We may also, for the purpose of treatment, disclose your protected health information to another health care provider when needed by the provider to render treatment to you.

For payment services: We will use your health care information to receive payment for services and products. We will bill you and /or a third -party payor such as your health insurance company for the cost of treatment. The information on or accompanying the bill may include your identification, diagnosis and treatment.

For health care operations: We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the federal Privacy Regulations. For example, we may compile your protected health information, along with that of other patients, in order to allow us to review that information and make suggestions concerning how to improve the quality of care.

Other uses and disclosure of protected health information permitted or required by regulation.
The following is a description of other possible ways we may use and /or disclose your protected health care information:

Friends and family: We may disclose your protected health information to friends and family in case of an emergency to the extent necessary to help with your health care or with payment or your health care. Using her judgment as health care professionals, our massage therapist may disclose protected information with a family member, other relative, close personal friend, or any person you identify as being involved in your health care.

Reminder calls: We may contact you to provide reminders of appointments or other health related services that may be of interest to you.

Other covered entities: We may disclose protected health information to another covered entity to conduct health care operations in the area of quality assurance activities.

Disclosure to the U.S. Department of Health and Human Services: When the U.S. Department of Health and Human Services is investigation or determining our compliance with the federal Privacy Regulations, we are required to disclose your protected health information to the DHHS.

Abuse or neglect: We may disclose your protected health care information to appropriate authorities if we believe that you may be a possible victim of abuse, domestic violence, neglect, or other crimes.

Serious threat to health or safety: We may disclose your protected health information if we believe that the disclosure is necessary to prevent a serious threat to your health or safety or the health and safety of the public or another person.

Public health and safety: We may release your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we may use information in your health record to the Food and Drug Administration relative to adverse events regarding drugs, foods, supplements, and other health products or to post marketing surveillance to enable product recalls or replacements.

Law enforcement: We may disclose to law enforcement agencies in response to a court order, subpoena, discovery request, administrative order, or other lawful process by another person involved in a dispute involving a patient, but only if efforts have been made to tell the patient about the request or to obtain an order protecting the requested health care information.

Other required or permitted disclosures: We may disclose your health care information to the following entities under given circumstances:
Whenever required to do so by law:

- To a correctional institution or its agents, if a patient is or becomes and inmate of such an institution, when necessary for the patient's health or the health and safety of others;
- To notify, or assist in notifying a family member, personal representative, or another person responsible for the patient's care, or the patient's location, or general condition;
- To the military authorities under certain circumstances when the patient is a member of the Armed Forces;
- To authorized federal officials for intelligence, counterintelligence, and other national security activities.

Authorized use and disclosure
We will obtain your written Authorization before using or disclosing your protected health care information for purposes other than those listed above or otherwise permitted or required by law. You may revoke an Authorization in writing at any time. Upon receipt of this revocation we will stop using or disclosing your protected health care information except to the extent that we have already taken action in reliance on the Authorization.

Patient Rights
Requests for Restriction: You have the right to request that we restrict how your protected health information is used or disclosed in carrying out treatment, payment, or health care operations. Such requests must be made in writing to Sukha Healing Arts Wellness Clinic (see address above), in your request tell us: 1) the information of which you want to limit our use and disclosure and 2) how you want to limit our use and/or disclosure of the information.

We are not required to agree to the requested restrictions, but if we do, we will abide by our agreement except in an emergency.

Access to protected health information: You have the right to look at or obtain a copy of your protected health information. You must make a request in writing to Sukha (See address above) to obtain access to your protected health information. If you request copies, we may charge you a reasonable fee for copies and postage (if you want them mailed).

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your protected health information, you may request that the denial be reviewed.

Accounting of Disclosures: You have the right to receive an accounting of the disclosures we have made on or after April 14, 2003, of your protected health information (PHI). We will provide the date on which we made the disclosure, the name of the person or entity to which we disclosed your PHI, a description or the PHI we disclosed, the reason for the disclosure, and certain other information.

Amendments to Health Care Information: You may request that we amend your protected health information if you feel that it is incomplete or incorrect. Your request must be in writing, and it must explain why the information should be amended. If we did not create the information you want amended or for certain other circumstances, we may deny your request. If we deny your request, we will provide you with a written explanation. If denied, you have the right to file a statement of disagreement with the decision.

For More Information or to Report a Problem
If you would like additional information or have questions about our privacy practices, you may contact Sukha at 206-429-2782 or by writing to the address above. You may also file a written complaint at this address. If you believe your privacy rights have been violated, you may file a complaint with Sukha or with the Department of Health and Human Services.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with the Department of Health and Human Services.