Client Massage Intake Form

Name: _____ Phone #1: _____ Phone #2: _____

Date of Birth: _____ Email: _____

Address: _____ (city) _____ (state) _____ (zip) _____

Emergency Contact: (name) _____ (phone #) _____ (relationship) _____

Occupation: _____ Employer: _____

Have you had therapeutic massage before? ☐ Yes ☐ No

Are you currently under the care of a Physician and/or Chiropractor? _____

Please list any injuries and/or surgeries: _____

Please list any allergies and/or sensitivities: _____

Please list all medications you are currently using: _____

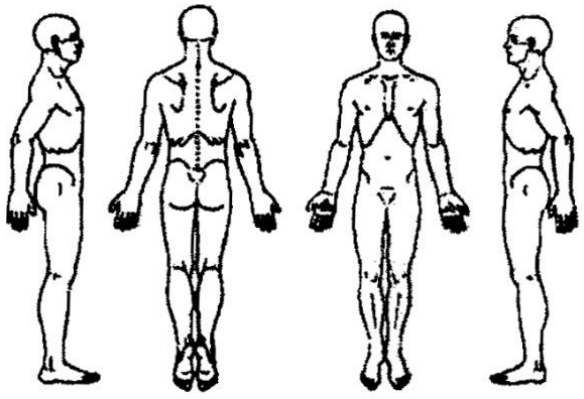
Please check all that apply:

☐ Headaches	☐ Neck pain	☐ Back pain	☐ Leg/Knee pain
☐ Jaw clenching/grinding	☐ Seizures	☐ High blood pressure	☐ Bruise easily
☐ Varicose veins	☐ Diabetes	☐ Numbness/tingling: if so, where? _____	

What is your exercise/training schedule? _____

_____

Please mark areas of pain, tension or discomfort on the diagram



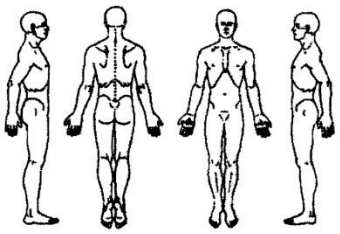
Please note our **cancellation policy**: We reserve the right to charge full price for any missed appointment or appointment cancelled within 24 hours of the scheduled time. We strive to create and maintain a professional and respectful environment. In turn, we appreciate your business and respect.

I am here to receive therapeutic massage. I understand that the Licensed Massage Therapist (LMT) will be providing therapeutic massage in accordance with the laws of the State of Texas Health Board. I agree to hold harmless and indemnify this massage establishment and LMTs against any and all liability arising from the application of massage therapy. I declare that I have provided the LMT with all relevant information necessary for the proper application of massage and I give my permission for such therapy. A LMT shall not engage in breast massage of female clients without separate written consent of the client. Modest draping will be used during the session. If uncomfortable for any reason, the client may ask the LMT to cease the massage and the LMT will end the massage session. Please be aware that deep tissue therapeutic massage can sometimes cause tenderness 24 to 48 hours after the treatment. This is a normal reaction and may be lessened by drinking extra water. By providing your signature at the bottom of this page, you acknowledge that you understand and agree to the above statements regarding our cancellation policy and terms of therapeutic massage.

Signature: _____ Date: _____

Date: _____

30 / 45 / 60 / 90



Date: _____

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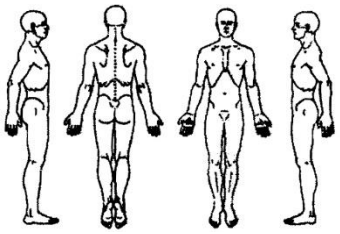

Date: _____

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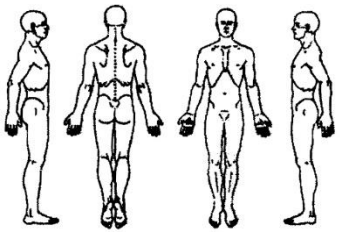

Date: _____

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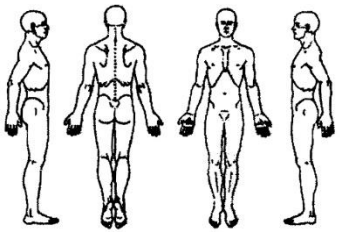

Credit Card Authorization Form

(Mandatory for all patients)

Patient Name: _____ Date of Birth: _____

The purpose of this form is to authorize RunLab to retain a valid credit card number on file for you as our patient. All patients are required to complete this form. This form will be kept confidential and only authorized staff will have access to the information. Your supplied credit card will be charged ONLY under the following circumstances:

1. Kimberly Mullen, DC, PLLC dba Back At It Sports Performance reserves the right to charge the credit card listed below weekly for all current patient balances under $250.00, including co-pays, deductibles, coinsurance and charges not covered by your insurance provider. A credit card receipt or itemized receipt is available on request. This notice serves as your consent to being charged for all current patient balances under $250.00 on your account. A representative from RunLab will contact you regarding balances over $250.00.

2. We value the time we have set aside to see and treat you. If you are not able to keep an appointment, we require 24 hours notice. There is a charge of $95 for late cancellations and no-shows. As a courtesy, a representative from RunLab will call the phone number on file to remind you of your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file. RunLab reserves the right to charge the credit card listed below $95 for our standard no-show fee. A receipt is available on request.

3. If we receive notice that a payment is returned to us for any reason, RunLab reserves the right to charge a $25 processing fee. You will have 10 business days to provide us with adequate payment method before your account is referred to collections. This notice serves as your consent to being charged for any returned payments.

Other than the conditions mentioned above, under NO circumstance would RunLab charge your credit card for anything not discussed personally with you. In conjunction with HIPAA regulations, all credit card information will be confidentially and securely stored via Transfirst Merchant Services. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted:
Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

_____ _____
Patient (Guardian) Signature Date

_____ _____
Staff Signature Date

Name As It Appears On Credit Card: _____

Billing Address: _____

AMEX / DISC / VISA / MC Number: _____

Expiration Date: _____ / _____ Verification Code (3 Or 4 Digits): _____