COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

As of July 1, 2001, the Freedom of Access to Complementary Care Law requires that, before receiving treatment, you be provided with the following information and acknowledge receipt of it by signing below.

Amiee Elizabeth is a therapist certified by the NCBTMB. She is in good standing with AMTA and is a member of the International Association of Healthcare Practitioners. Here is a complete list of her credentials.

"THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY. Under Minnesota law, an unlicensed complementary and alternative healthcare practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of healthcare provider, the client may seek such services at any time."

• Any concerns you might have, address with your craniosacral therapist.
• If your concerns have not been met, you have the right to express them and file your complaints with: the *Minneapolis Police Department* or the *Minnesota Department of Health.*
• You have the right to 30 days notice of changes in services or charges. Current fees as of December 1, 2025, are: 60-minute session $130, 90-minute session $162, 2-hour session $220. Full session fee is due if cancellation occurs within 24 hours of the appointment scheduled.
• Massage is the systematic and scientific manipulation of the soft tissues of the body to prevent and alleviate pain, discomfort, muscle spasm, and stress; as well as promote health and wellness. I utilize Craniosacral and somatoemotional release therapies, lymphatic techniques and myofascial release work.
• You have the right to complete and current information concerning any massage-specific assessment your therapist has made and any recommended service to be provided, including the expected duration of service.
• You may expect courteous and respectful treatment from massage therapists and to be free from verbal, physical, or sexual abuse by therapists and facility staff.
• Your records and all transactions with the facility are confidential, unless the release of these records is authorized in writing by you, or otherwise provided by law.
• You have the right to access and read your records in accordance with sections 144.291 to 144.298
• Other massage and bodywork services may be available to you in the community. Please ask your massage therapist or facility staff member for any information you would like.
• You have the right to choose freely among available massage and bodywork practitioners and to change practitioners after services have begun, within the limits of health insurance or other health programs.
• You have the right to coordinate the transfer of your records when there will be a change in the provider of services. If you choose to see another massage therapist or healthcare provider, your records will be transferred at your request.
• You have the right to refuse treatment at any time during a massage therapy session.
• You may assert the above mentioned rights without retaliation from the massage therapist.

First Name _____

Last Name _____

Email Address _____

Home Phone # _____

Street Address _____

State _____

Emergency contact name _____

Emergency contact relationship _____

Emergency phone # _____

Date of initial visit _____

Date of birth _____

Referred by _____

Mobile Phone # _____

Work Phone # _____

City _____

Zip Code _____

Physician's name _____

Physician's phone # _____

How would you rate your general health?

◯ Excellent ◯ Good

◯ Fair ◯ Poor

Have you had a professional massage before?

◯ Yes *(Date of last treatment)* _____

◯ No

List current medications & the conditions they are treating

List any major accidents or surgeries (including dates)

Please tell us about any allergies or hypersensitivities

Reason for initial visit

HEAD NECK

- ◯ Headaches / migraines
- ◯ Vertigo / dizziness
- ◯ Ringing in ears
- ◯ Hearing loss
- ◯ Vision problems
- ◯ Vision loss

RESPIRATORY

- ◯ Asthma
- ◯ Shortness of breath
- ◯ Chronic cough
- ◯ Bronchitis
- ◯ Emphysema
- ◯ Sinusitis
- ◯ Frequent colds
- ◯ Smoker
- ◯ Family history of respiratory difficulties

NERVOUS SYSTEM

- ◯ Sensory loss / change
- ◯ Numbness / tingling
- ◯ Sciatica
- ◯ Epilepsy
- ◯ Seizures
- ◯ Multiple sclerosis

MUSCULOSKELETAL SYSTEM

- ◯ Arthritis
- ◯ Family history of arthritis
- ◯ Osteoporosis
- ◯ Tendonitis
- ◯ Bursitis
- ◯ Jaw pain (TMJ)
- ◯ Pins / plates / wires / artificial joint

REPRODUCTIVE

- ◯ Pregnant
- ◯ Given birth
- ◯ Gynecological problems

CARDIOVASCULAR

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart attack
- ◯ Stroke
- ◯ Heart disease
- ◯ Poor circulation
- ◯ Phlebitis / varicose veins
- ◯ Pacemaker
- ◯ Hemophilia
- ◯ Chronic congestive heart failure
- ◯ Family history of cardiovascular problems

SKIN & INFECTIONS

- ◯ Hepatitis
- ◯ HIV / AIDS
- ◯ Herpes
- ◯ Tuberculosis
- ◯ Lyme disease
- ◯ Infectious skin conditions

OTHER CONDITIONS

- ◯ Cancer
- ◯ Diabetes
- ◯ Unexplained weight loss
- ◯ Digestive conditions
- ◯ Fibromyalgia
- ◯ Chronic fatigue syndrome
- ◯ Depression
- ◯ Anxiety
- ◯ Psychiatric disorder
- ◯ Other conditions _____

_____

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_____

It is my choice to receive massage therapy. I am aware of the benefits and risks of massage and give my consent for massage. I understand that there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

I understand that my personal health information will be collected. I understand that all information that I provide will be kept confidential unless required by law. I understand and consent that my medical information may be shared by the various care providers involved in my care and treatment.

Treatments may be covered by extended health care plans. I understand that it is my responsibility to confirm the exact details of my coverage.

Signature: _____ Date: _____