Welcome

Welcome to Stonington Natural Health Center. We are so glad you made it here.

Here at Stonington Natural Health Center, we provide *Custom Holistic Healthcare for the Whole Family in a Tranquil Waterfront Setting*. We offer Acupuncture & Chinese Medicine Treatments, the SNHC Customized Massage which is a combination of Swedish and Deep Tissue Massage to your desired level of pressure, Pregnancy Massage, Chakra Balancing, Reiki, and Herbal Consultations.

Our treatments help you to feel better, breathe more deeply, rejuvenate, and let go of your worries. Your body, mind, and spirit will thank you. This is your time to relax and heal, initiate and speed up the healing process of your body, so that you can live a longer, healthier, and happier life.

For injuries, pain, and health problems, you will receive the most benefit when you come in before the effects of the previous treatment disappear. Your practitioner will give you a treatment protocol recommendation. It is often recommended to group your treatments close together, perhaps daily, twice a week or three times per week. During times of stress, anxiety, or depression, it is helpful to come in for Acupuncture and Massage treatments anywhere from once a week to daily. Slow and steady wins the race, as we shift the energy over. Once you are feeling better, we slowly space the treatments apart as the positive effects hold. Our goal is to shift the pattern of your energy, with long lasting effects, to get you better and create long-term good health. Once you are feeling great, regular tune-ups are important to maintain good health.

If you have any questions, concerns, or feedback, please talk with us, call us at 860.536.3880, or email us at info@snhc.com.

We appreciate this opportunity to contribute to you on your path towards optimal health and happiness.
ALL OF US AT STONINGTON NATURAL HEALTH CENTER

The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease.
THOMAS EDISON

All life is an experiment.
The more experiments you make the better.
RALPH WALDO EMERSON

Enjoy the journey.
DEEPAK CHOPRA

FINANCIAL POLICIES FOR TREATMENT AND CARE

Your treatment time is reserved for you. To change, reschedule, or cancel an appointment, please call **at least two business days, 48 business hours, before your appointment time.** This gives us time to fill your appointment. If no one answers, please leave a message. For Monday appointments, please call by Thursday. For Tuesday appointments, please call by Friday.

"Minimum 48 Hours Cancellation Policy": Because we have made preparations and staffing for your appointment, we ask for at least two business days, 48 business hours notice to reschedule or cancel your appointment. With LESS THAN 24 BUSINESS HOURS, your credit card will be charged for your appointment or treatment packages will have one treatment deducted.

We appreciate your cooperation as this is **vitally important for our mutual success.** We make reminder texts or calls as a courtesy; you are ultimately responsible, however, for coming to your appointments. It is also our courtesy that if you or we are able to fill your appointment, you will not be charged, and we encourage you to substitute a friend or family member.

If you are running late, please call or text to let us know. We would rather you come and have a shorter treatment than miss your appointment. Ideally, please arrive a few minutes before your appointment to use the restroom, make purchases, set up your next appointments, and unwind.

Payment: In an attempt to keep health care costs low, preferred methods of payment are cash or check. Payment is required at the time of your service. We also accept credit cards.

Treatment Plans: Dr. Marco and/or your Licensed Massage Therapist will develop your treatment plan to help you accomplish your goals and feel your best. Follow your Treatment Plan to achieve optimal results. If it has been over a year since you have seen Dr. Marco, it is recommended to come in for a ReActivation appointment to go over your health history.

Treatment Packages and Massage Memberships: (1) make check-out easier, (2) lower the price, and (3) help you complete your treatment goals. Treatment Packages and Massage Memberships are not refundable, can only be used for the services purchased, and expire one year after purchase.

Return Policy: Treatment Packages and Memberships, Gift Certificates, and products are non-refundable. We guarantee quality and cannot sell returned herbs, supplements, or products.

Your credit card number is encrypted in MindBodyOnline. Patients enjoy this convenience to pay for special orders, Gift Certificates, treatments, packages, herbs, missed or canceled appointments, and for guarantying personal checks. You can type into MindBody before your appointment or hand us your credit card for us to input not write here, or upon receiving this form, we enter your credit card information and delete it from this form.

The following information is required to receive treatments:

Visa/MasterCard/American Express/Discover (Please circle one)

_____ _____/_____ _____

Credit Card Number Expiration Month year 3 digit code on back

_____

Billing Address

I have read, understand, and agree to the above information:

_____ _____ _____

Signature **Printed Name** **Date**

Client Intake Form

Please be aware that massage therapists abide by a code of ethics that ensures and protects client confidentiality; no information about a client is shared or disclosed unless the client gives informed consent.

Name_____ Today's date_____

Email address (for specials & events) _____

Address _____

Please circle which phone number you prefer to be contacted at:

Home _____ Work _____ Cell _____Prefer Texting? Y N

Employed By_____Occupation/Profession_____

Date of birth _____Age_____ Referred By_____

Emergency Contact _____Phone #_____Relationship_____

Significant other or Spouse's Named_____

Ages of Children & Names_____

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Have you had a massage before? _____When?_____

Reason for today's visit: _____

Any areas you would like me to avoid? (i.e. ticklish areas) _____

Do you wear contact lenses and or hearing aid? _____

# of glasses of water per day _____ Hours of sleep?_____ Are your bowels regular? _____

Do you have reason to believe you may be pregnant? Y N Due date_____

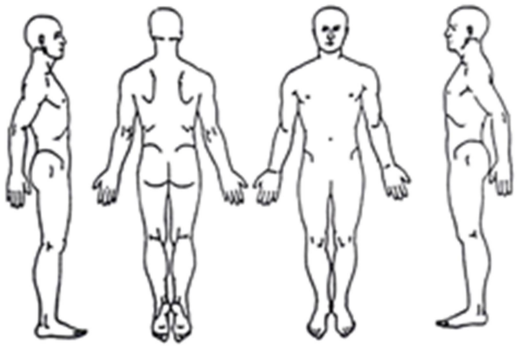
Do you belong to a fitness facility? Y N

List any recent injuries, surgeries, accidents or medical treatments? _____

_____

_____

Pain and discomfort can be traced back to many different origins. Please describe your complaint below, and mark the affected area(s) on the figure shown here:



_____

_____

_____

_____

_____

Please list any allergies you may have:

_____

Are you presently taking medication or supplements? Y / N If yes, please include:

_____

_____

Please Check any of the following conditions:

Musculoskeletal

- ❑ Fibromyalgia
- ❑ Spasms/Cramps
- ❑ Sprains/Strains
- ❑ Osteoporosis
- ❑ Postural Deviations
- ❑ Gout
- ❑ Osteoarthritis/Rheumatoid Arthritis
- ❑ TMJ
- ❑ Cysts
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Whiplash Syndrome
- ❑ Carpal Tunnel
- ❑ Headache
- ❑ Leg Pain
- ❑ Arm/Shoulder Pain
- ❑ Lower Back Pain
- ❑ Mid Back Pain
- ❑ Hip Pain
- ❑ Other _____

Respiratory

- ❑ Pneumonia
- ❑ Sinusitis
- ❑ Asthma
- ❑ Trouble Breathing
- ❑ Dizziness

Circulatory

- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low blood pressure
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Heart Condition
- ❑ Blood Clots/Phlebitis
- ❑ Diabetes
- ❑ Edema
- ❑ Other _____

Digestive

- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Hepatitis
- ❑ Gallstones
- ❑ Chron's Disease
- ❑ Diarrhea
- ❑ Gas/Bloating
- ❑ Indigestion
- ❑ Other _____

Skin

- ❑ Fungal Infections
- ❑ Acne
- ❑ Impetigo
- ❑ Dermatitis/Eczema
- ❑ Psoriasis
- ❑ Open Wounds or Sore
- ❑ Rashes
- ❑ Warts/Moles
- ❑ Athletes Foot
- ❑ Other _____

Nervous System

- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson' Disease
- ❑ Bell's Palsy
- ❑ Spinal Cord Injury
- ❑ Seizure Disorders
- ❑ Numbness/Tingling/Twitching
- ❑ Other _____

Other

- ❑ Insomnia
- ❑ Anxiety/Panic Attacks
- ❑ Grief Process
- ❑ Cancer
- ❑ Substance Abuse
- ❑ Chronic Fatigue
- ❑ HIV/AIDs
- ❑ Lupus
- ❑ Kidney disease
- ❑ Bladder Infection
- ❑ Other _____

Are you currently under a doctor's care? ____ Doctor's Name and number_____

The above information is accurate to the best of the knowledge. I understand that massage therapists are neither trained nor licensed to provide medical treatment, diagnose, prescribe medications, perform spinal or joint manipulation, nor any other service for which a license to practice medicine, chiropractic, naturopathy, physical therapy or podiatry is required by law. I understand that massage therapy is not a substitute for medical attention or examination. I assume full responsibility for alerting the practioner to any changes to my health. I am responsible for payment for services rendered. I consent to receiving Massage, Reiki, Facials, and any other health service of Stonington Natural Health Center.

Client Signature _____ Date _____

COVID-19 INFORMED CONSENT TO TREAT

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. Part of this office's role is to 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.

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

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person- to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: _____

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective 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.

Patient Signature	_____	Parent/ Guardian Signature	_____	Witness Signature	_____
Name	_____	Name	_____	Name	_____
Date	_____	Date	_____	Date	_____