Fossé Restorative Therapy: therapy with a neural twist 352-256-2800
Nathalie Fossé, PhD -- LMT

Information Form

Name _____ Middle _____

Date of Birth _____ Age _____

Address: _____

City _____ State _____ Zip Code _____

Phone: Cell _____ Home _____ Work _____

Email address : _____

Referred by _____

Emergency Contact: Name _____

Phone(s) _____ Relationship _____

- I understand that the information I give on this form will be confidential and will be used for no other purpose than treatment and session protocol.
- I understand that the services offered by Fossé Restorative Therapy are not a substitute for medical care. If I experience any pain or discomfort during my session, I agree to inform the practitioner immediately, so that the exercise or massage technique may be adjusted to my level of comfort. _____ **Please initial**
- I have stated all medical conditions that I am aware of and will keep my practitioner informed of any changes.
- It is understood that the services I receive are strictly therapeutic and non-sexual in nature.
- I understand I am financially responsible for my appointments and that the payment is due at the time of service. _____ **Please initial**

- I agree to provide 24-hour cancellation notice. If I fail to do so, I agree to pay the full appointment fee. ____ **Please initial.**

HIPPA and NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPPA) were established by the US government to establish rules concerning the use and protections of medical and health information. The rules are intended to provide standard privacy protections for your medical information. We regard the privacy of our clients as a central part of our mission to serve the needs of the client first. Private controlled use of your information by staff is essential to your care. The notice of Privacy Practices provides you with information explaining how we use your medical information. I acknowledge that I have been offered a copy of the Notice of Privacy Practices as required by HIPPA. I understand that this acknowledgement means only that I have received the notice and in no way affects the care I receive.

Patient (responsible arty) Signature: _____Date: _____

How to submit your intake form:

Print, and bring the completed form with you at the time of your appointment.

Submit by email***** to Nathalie at nathalie@fossert.com

****NOTE**: Email sent over the Internet is not necessarily secure. Please be aware that Fossé restorative Therapy (FRT) cannot guarantee the confidentiality or security of any information sent over the Internet when using email. FRT shall not be liable for any breach of confidentiality resulting from such use of email via the Internet.

List of medications / herbs/vitamins

Name	dosage	reason for taking it

Medical history

Have you had or do you presently have any of the following conditions? (Check if yes.)

☐	High blood pressure	☐	Orthopnea
☐	Low blood pressure	☐	Nocturnal dyspnea
☐	Blood clots (DVT)	☐	Shortness of breath at rest or with mild exertion
☐	Varicose veins	☐	Chest pain or pressure
☐	Edema	☐	Palpitations or tachycardia
☐	phlebitis	☐	Pain, discomfort in chest, neck jaw, arms, or other
☐	lymphedema	☐	Heart attack
☐	Rheumatic fever	☐	Heart murmur
☐	neuropathy	☐	Unusual fatigue or shortness of breath with normal
☐	Numbness/tingling	☐	Temporary loss of visual acuity or speech, or short-
☐	arthritis	☐	Lung disease
☐	Cancer/tumors:	☐	Seizures
☐	headaches	☐	Fainting or dizziness
☐	sinus problems	☐	epilepsy
☐	Migraine headaches	☐	glaucoma
☐	Intermittent claudication (leg or hip cramping)	☐	Diabetes
☐	Muscles/joints pains	☐	High cholesterol
☐	Sprains/strains	☐	Sleep difficulty
☐	Injury to back or knees	☐	Depression -
☐	Chronic pain	☐	skin problems. Specify:
☐	Tendonitis	☐	Jaw pain/teeth grinding
☐	Whiplash	☐	Allergies:
☐	Scoliosis	☐	pregnant
☐	Surgeries, recent or old	☐	Endometriosis - Painful menstruation
☐	Others:		

Agreement of Release and Waiver of Liability

This form covers all services offered by Fossé Restorative Therapy, LLC. Please fill out the following, being sure to read each paragraph.

I, _____, hereby agree to the following:

that I am participating in Restorative Therapy sessions with Fossé Restorative Therapy, LLC, during which I receive information and instruction about healthy and safe practice. I recognize that these sessions may require physical exertion, which may be strenuous and could result in physical injury, and I am fully aware of the risks ad hazards involved.

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in Restorative Therapy sessions.

I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the program. I agree to inform my instructor/teacher of any physical limitations, physical discomfort and/or injuries before or during classes, and I take full responsibility for nondisclosure.

In further consideration of being permitted to participate in Restorative Therapy sessions, I, my heirs and legal representatives knowingly, voluntarily and expressly waive any claim I may have against Fossé Restorative Therapy, LLC for injury or damages that I may sustain as a result of participating in this program.

I have read the above release waiver of liability and fully understand its contents. I voluntarily agree to its contents. I voluntarily agree to the terms and conditions stated above.

Signature of Participant: _____Date: _____

If participant is under 18:
As legal guardian of _____, I consent to the above terms and conditions.

Signature of Participant: _____Date: _____