SMART
integrative massage group

94 Valley Road # 2A, Montclair, NJ 07042 646 Route 18 North, Bldg. B, Suite #210, East Brunswick, NJ 08816
973-744-1576 smartmassagegroup@gmail.com

Client Name: _____ Date: _____

This document contains important information about your decision to receive services in light of the COVID-19 public health crisis. Please read and fill out this form carefully and let me know if you have any questions.

COVID-19 Information

Please answer these COVID-19 health questions below:

1)Have you been vaccinated for COVID -19? Yes ☐ No ☐ Any after vaccination side effects? _____
Date of 1st dose_____ Date of 2nd Dose_____ Boosters: _____

2) Have you been recently tested for COVID-19? Yes ☐ No ☐ If YES, what type of test did you have? _____
When were you tested? _____ What was the result? _____

3) Please check if you are experiencing any of the following as a NEW PATTERN: _____ Sinus congestion or runny nose _____ Fever or chills _____ Cough_____ Sore throat _____ Muscle or body aches _____ Shortness of breath or difficulty breathing _____ Chest pressure _____ New loss of sense of taste or smell _____ Diarrhea, nausea, vomiting_____ Fatigue _____Headaches _____ Rash or skin lesions (especially on the feet) _____Sudden onset of muscle soreness (not related to a specific activity)

4) Have you had a fever in the last 24 hours of 100.4°F or above? Yes ☐ No ☐

5) Have you been in contact with anyone in the last 14 days who has been diagnosed with COVID-19 or had coronavirus, flu-like type symptoms? Yes ☐ No ☐ You may answer "No" if you are a healthcare worker whose only exposure to individuals with suspected or confirmed COVID-19 has been in a healthcare setting in which you were wearing appropriate personal protective equipment.

6) Have you been asked to self-isolate or quarantine by a doctor or a local public health official in the last 14 days? Yes ☐ No ☐

7) Have you traveled anywhere outside of the state in the last 14 days? Yes ☐ No ☐ Location: _____

8) Have you done any air travel - domestic or international in the last 14 days? Yes ☐ No ☐ Location: _____

9) Within the last 14 days, have you been in places with a high infection rate, where people have not been isolating (no stay-at-home order), or been in any groups of people - large or small - where social distancing was not observed (e.g., protests, designated "hotspots")?
Yes ☐ No ☐ If yes, please explain. _____

10) What precautions have you taken to limit your exposure to the virus? _____

11) Do you spend time around anyone considered high-risk, such as the elderly with co-morbidities or immuno-compromised family members? Yes ☐ No ☐

The following questions are specific to a new aspect of COVID-19 involving blood coagulation especially in those who had confirmed cases of COVID-19.

12) Are you able to exercise to get your heart rate and respiratory rate up without any problem? Yes ☐ No ☐

13) Have you had a new onset of muscle aches and pain since the emergence of the virus? Yes ☐ No ☐

14) Have you seen any new marks, rashes, spots, bumps, or other lesions on your skin? Yes ☐ No ☐

I declare that the information provided above is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

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

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Consent for Treatment

Client Name: _____

To proceed with receiving care, I confirm and understand the following (Please initial in all places provided):

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. _____**INITIAL HERE**

I understand that I am the decision-maker for my health care. To the best of their ability, my practitioner will 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 healthcare during a pandemic. Given the current limitations of COVID 19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult. _____ **INITIAL HERE**

I understand that the health conditions listed below place me at higher risk for serious COVID-19 infection:

> People 65 years or older, Children with underlying health conditions; Pregnant women, Neurologic conditions (e.g., dementia); Lung conditions including moderate to severe asthma, chronic obstructive pulmonary disease, pulmonary fibrosis, and cystic fibrosis; Cardiovascular conditions including heart conditions and hypertension; Blood disorders (sickle cell disease and thalassemia); Cerebrovascular diseases (a disease that affects blood vessels and blood supply to the brain); Compromised or suppressed immunity from HIV/AIDS, cancer treatment, organ transplant or bone marrow transplant recipients, use of corticosteroids, immune deficiencies from medications; Severe obesity (BMI 30 or higher); Diabetes type 1 and 2; Chronic kidney diseases (undergoing dialysis); Liver diseases; Smokers.

If I have one of these conditions I should forgo massage therapy while COVID-19 is still present in my community, or obtain my physician's consent. Should I decide to proceed with massage therapy, I assume all risks related to COVID-19 infection. _____ **INITIAL HERE**

I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____ **INITIAL HERE**

I understand that if a client, therapist, or staff member of this facility tests positive for COVID-19 within a time that places me at risk of exposure, my name, and contact information will be shared with the State Department of Health for their follow-up. If I develop symptoms of illness within two weeks of my massage appointment, I will contact this massage facility immediately. _____ **INITIAL HERE**

I have been offered a copy of this consent form. _____ **INITIAL HERE**

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.

Signature: _____ Date: _____

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

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Protocols when arriving and in-office

As per our state guidelines as well as recommendations from the CDC and our national massage organizations, we have adopted the following protocols for in-office appointments:

· Clients should arrive at their appointment 10 minutes early.

· Clients are required to wear a mask when entering and exiting the building. Non-vaccinated clients are required to wear a mask throughout their massage sessions. The therapist will wear a mask when working on non-vaccinated clients. Therapists are happy to accommodate any client request to wear masks during the session even if both are vaccinated. If mask-wearing is required by public health officials, both the therapist and the client will be required to wear masks throughout the session.

· Clients are asked to use the building restroom within our suite which is completely disinfected between sessions.

· Clients may be asked to remove shoes before entering the office suite and wash hands in the bathroom or use hand sanitizer immediately upon entering the treatment room. If the client arrives wearing medical gloves, I will request that the client disposes of these gloves before entry, as the gloves may be contaminated.

· If a client has a temperature above 100.4°F, or if they have developed cold or flu-like symptoms or other symptoms suggesting illness, they will be asked to reschedule their massage session. It is suggested that they call their primary care provider for consultation. No cancellation fee or penalty will be incurred.

· Friends and family of the client are not allowed to wait in the building while the client receives massage unless they are that client's legal guardian. Masks must be worn while in the common waiting areas of the building.

· Hand sanitizer is available for use when leaving the office and the building.

AFTER YOUR SESSION

· For 14 days following your session, clients should share with the office if they have developed any cold or flu-like symptoms or tested positive for COVID-19.

· Massage therapists are not authorized to share the health data of their clients without the client's written consent except for the client's name and contact information when contacted by the public health department. However, should a client develop symptoms of COVID-19 within two weeks of a session, the office may contact the local health department for consultation and guidance.

· Please consult our website at smartmassagegroup.com for changes or updates to these policies.

Signature: _____ Date: _____

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

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COVID- 19 Cancellation Policy

Client Name: _____ Date: _____

Amid the ongoing uncertainty of COVID-19, we have modified our cancellation policy to offer greater flexibility to all our clients. We hope this will alleviate any stress and hesitation you have about an upcoming appointment. If you need to reschedule for whatever reason, and especially if you are not feeling well, we understand and request you to please contact us as soon as possible to reschedule. To further support you, there will be no penalties for cancellations at this time.

Tardiness

Appointment times are as scheduled and cannot extend beyond the stated time to accommodate late arrivals. Please plan to arrive 10 minutes before your scheduled appointment to allow ample time for a per-session consultation with your massage therapist.

Sickness

Massage/bodywork is not appropriate care for infectious or contagious illnesses. Please cancel your appointment as soon as you are aware of an infectious or contagious condition. This includes common cold symptoms. Even if it is within the 24-hour notice period, there will be no penalties for cancellations during this pandemic state of emergency from the governor.

Please be advised of these special COIVD-related cancellation policies for this office. Your signature below signifies acceptance of these policies. Once the pandemic state of emergency is lifted by the governor, this office will resume our normal cancellation policies listed on our website and you agree to abide by those policies going forward from such time.

Signature: _____ Date: _____

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