# HEALTH AND SAFETY PROCEDURES

## *Covid 19 Update: I have completed vaccination as of 2/13/21*

This healthcare practice follows general pandemic safety provisions of the State of Maryland and Howard and Montgomery Counties, as well as infection control recommendations from U.S. Centers for Disease Control and Prevention (CDC) and the Federation of State Massage Therapy Boards (FSMTB) Massage and Bodywork Guidelines.

### SAFETY STEPS THAT MUST BE FOLLOWED FOR ALL APPOINTMENTS:

- Appointments must be ***booked and confirmed by email/phone at least 12 hours in advance***; no walk-in appointments will be accepted. Appointments will be managed to allow for social distancing between patients, which might mean that you're offered limited options for scheduling your appointment.
- A form listing COVID-19 Screening Questions that you will be asked when you arrive for your appointment is attached and posted on the LessInPainMassage.com website. Please ***review these Screening Questions before you arrive*** and be prepared to answer all questions in writing on arrival. Please bring your own pen.
- The following forms, also attached and posted on the website, preferably should be ***completed, signed and brought to your initial appointment*** for review prior to treatment:
  (1) Standard Health History required for massage therapy;
  (2) Informed Consent Agreement regarding risks of COVID-19 infection and sharing of contact information with State officials in case a client or therapist becomes infected.
- All clients and therapist are required to ***wear face masks at all times*** everywhere inside The Wellness Suite and Home Office facilities, including during massage therapy. Therapist will provide a disposable surgical face mask for you if you do not bring your own.
- Please arrive 15 minutes early and ***wait outside*** the Office door (at The Wellness Suite, #303) or outside the front door (Home Office), ***until staff admits you at your appointment time***.
- The therapist will meet you at the door at your appointment time, ask you to use provided hand sanitizer and, if needed, provide a mask. ***Only clients receiving treatment may enter the building unless absolutely necessary***; escorts should remain outside.
- The therapist will then escort you to the treatment room, check your temperature, review the Screening Questions and your completed and signed Informed Consent forms. Clients NOT meeting all safety requirements will need to leave and reschedule at least two weeks later.
- Clients cleared for safety will then review Health History and plan and receive treatment.
- After treatment, clients will be asked to dress and, if needed, make payment in the therapy room, then leave the facility as soon as possible; and, preferably, to set future appointments online.


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**ADDITIONAL SAFETY PROCEDURES WE WILL FOLLOW:**

- Decontaminate session room air during sessions using portable High-Efficiency Particulate Air ("HEPA") filter units and between clients by opening doors to circulate fresh air.
- Disinfect all high-touch surfaces (surfaces that are handled frequently by numerous people) in the waiting area, treatment room and restroom, after each client session, with an EPA-registered disinfectant.
- Disinfect all massage therapy tools and material dispensers after each client.
- Cover treatment table and head rest with plastic coverings under linens, change linens and disinfect plastic coverings between clients, and wash all soiled linens according to FSMTB safety guidelines.
- Clean all floors (MT room, entrance hallway and restroom on a regular basis).
- Therapist will wash hands and arms with soap and water and then apply an alcohol-based hand sanitizer directly before and immediately after each therapy session.
- In the event that therapist suspects that he has been exposed to COVID-19, he will self-isolate until he can obtain testing and be cleared of infection.


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LESS-IN-PAIN
THERAPEUTIC MASSAGE
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# MASSAGE THERAPY COVID-19 INFORMED CONSENT FORM

(a) I understand that close contact with people increases the risk of infection from COVID-19. By signing this form, I acknowledge that I am aware of the risks involved and give consent to receive massage from this practitioner.

(b) I further understand that, unless otherwise directed by their primary healthcare provider, people at higher risk of severe illness from COVID-19 should forgo massage while the virus is present in their communities, including people with any of the following underlying conditions:

› Age 65 years or older

› Chronic lung disease

› Moderate to severe asthma

› Heart conditions

› Compromised or suppressed immunity

› Severe obesity (body mass index of 40 or higher)

› Diabetes

› Chronic kidney disease

› Liver disease”

(c) I also understand that my name and contact information might be shared with the state health department in the event that a client or practitioner at this facility tests positive for COVID-19. My contact details will only be shared in the event they are relevant based on suspected exposure date, and only for appropriate follow-up by the health department.

_____

(print name)

_____

(signature)

_____

(date)



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# COVID-19 SCREENING QUESTIONS

**Therapist reserves the right to require any client to reschedule a massage therapy appointment** if client answers YES to one or more of Questions 2-8, below, immediately prior to the appointment.

1. Have you received any **Covid vaccination**? Check one: __ **YES** __ **NO**

   If YES:**Type:** Moderna / Pfizer / J&J / Other/Unknown #1 Date:___/___/21 #2 Date:___/___/21

2. Is your current temperature over **100.4°F** Check one: __ **YES** __ **NO**

   Temperature scan _____ °F performed by (staff initials) _____

3. Have you/anyone in your household been **tested for COVID-19**? Check one: __ **YES** __ **NO**

   If YES, what type of test did you have?_____

   When was your test?_____

   What were the results? _____

4. Have you/anyone in your household had **contact with a person who tested positive** for COVID-19 or was **quarantined** as presumptively positive? Check one: __ **YES** __ **NO**

5. Have you been in a **place with a high infection rate** in the last two weeks (e.g., CDC/state designated **"hotspots"**)? Check one: __ **YES** __ **NO**

   If YES, please explain. _____

6. Have you **gathered with over 10 people** in the last two weeks Check one: __ **YES** __ **NO**

   If YES, please explain. _____

7. Are you experiencing any of the following as a **NEW PATTERN during the pandemic?**

   If yes, please check all that apply: Check one: __ **YES** __ **NO**

   __ Fever __ Chills __ Cough __ Sore throat __Nasal, sinus congestion

   __ Diarrhea/digestive upset __Loss of sense of taste or smell __ Shortness of breath

   __ Fatigue __Sudden onset of muscle soreness (not related to any specific activity)

   __Rash or skin lesions (especially on the feet)

8. Do you have any NEW discomfort with exertion or exercise? Check one: __ **YES** __ **NO**

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

_____ _____

(print name) (signature)

_____

(date)



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# Massage Client Intake Form

Name _____ Phone ( _____ ) _____ DOB _____

Address _____ City _____ State _____ Zip _____

E-mail: _____

Referred by: _____ Phone ( _____ ) _____

In case of emergency: _____ Phone ( _____ ) _____

Occupation _____ _ Male _ Female Physician _____

Health Insurance Carrier _____

**Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided.**

Have you ever experienced a professional massage or bodywork session? ❑ Yes ❑ No How recently? _____

What are your massage or bodywork goals? _____

What kind of pressure do you prefer? light medium firm

***If you answer "yes" to any of the following questions, please explain as clearly as possible in Comments or OVER.***

Yes No Do you frequently suffer from stress?
Yes No Do you have diabetes?
Yes No Do you experience frequent headaches?
Yes No Are you pregnant?
Yes No Do you suffer from arthritis?
Yes No Are you wearing contact lenses?
Yes No Are you wearing dentures?
Yes No Do you have high blood pressure?
Yes No Are you taking high blood pressure medication?
Yes No Do you suffer from epilepsy or seizures?
Yes No Do you suffer from joint swelling?
Yes No Do you have varicose veins?
Yes No Do you have any contagious diseases?
Yes No Do you have osteoporosis?
Yes No Do you have any allergies? (list in Comments)

Yes No Do you bruise easily?
Yes No Any broken bones in the past two years?
Yes No Any injuries in the past two years?
Yes No Do you have tension or soreness in a specific area?
Please specify _____
_____
Yes No Do you have cardiac or circulatory problems?
Yes No Do you suffer from back pain?
Yes No Do you have numbness or stabbing pains?
Yes No Are you sensitive to touch or pressure in any area?
Yes No Have you ever had surgery? Explain below.
Yes No **Other medical condition(s) or any medication(s) that I should know about? (list below)**

**Comments** _____
_____

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability for the practitioner should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances I make will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____

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***Consent to Treatment of Minor:*** By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____



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