**Spirit of Healing**

**Client Notification Form**

**Please read the following prior to contracting for services:**

Name of Practitioner: Alyssa Ryan Calm, LMT, CILT

Licensed Massage Therapist

Craniosacral Therapist

Certified Independent Lactation Therapist

Business Address: 5115 Olentangy River Road

Columbus, OH 43235

Telephone number: (614) 326-3504

**The following is a brief description of my education, training, experience, and credentials:**

I have a Bachelor Degree in Communication from Florida Gulf Coast University and am a Certified Independent Lactation Therapist (CILT). I am a Licensed Massage Therapist (LMT) and Craniosacral Therapist. I began my CILT training with Alison Hazelbaker, PhD, IBCLC, CST in February of 2015 and began my Craniosacral training with Upledger Institute in May 2016, I have taken advanced Craniosacral training specializing in working with infant trauma and breastfeeding issues with Alison Hazelbaker. I began my education in Massage Therapy with Columbus State Community College in January of 2020 and received my license in September 2021.

Note: The State of Ohio has not adopted any educational or training standards for persons who provide information or perform craniosacral therapy or lymphatic drainage therapy to clients. This statement of credentials is for informational purposes only. Under Ohio law craniosacral and massage therapists are not allowed to provide a diagnosis or to recommend discontinuance of medically prescribed treatment. If you desire a diagnosis from a licensed healthcare practitioner, you may seek those services at any time.

Certified Independent Lactation Therapists are recognized as autonomous practitioners in all states. It is within my scope of practice to make lactation diagnoses, lactation prescriptions and to perform lactation therapy.

I have read and understand the Therapy and Credentials section. : \_\_\_\_\_\_\_ (Please initial here)

FINANCIAL POLICY SECTION

**Fees**

My fees are $100 per hour for lactation services (weight checks and follow-up phone calls are free for the first 15 minutes and are billed by the quarter hour for time spent after the initial 15 minutes) and $100 per hour for craniosacral and massage therapy treatments. I bill by the quarter hour. I reserve the right to increase my fees and will notify you of any fee increase at least one (1) month before the increase takes effect. Payment is due in full at the time of service unless an alternative payment arrangement has been made. I accept cash, checks, Visa, MasterCard, American Express and Discover. I also accept Health Savings Account cards for payment. If fees are not paid in full, I reserve the right to charge interest in the amount of 18% annually for the fees not paid.

Credit card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize \_\_Spirit of Healing, LLC\_\_\_\_ to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

**Insurance**

I do not directly bill insurance companies, nor do I accept assignments from insurance companies.

Insurance companies may reimburse for Lactation Services, Craniosacral Therapy or Massage Therapy. I DO NOT GUARANTEE SUCH REIMBURSEMENT. I can provide you with a superbill for Lactation Services (upon request only) or a CPT coded receipt for Craniosacral or Massage Therapy should you need to file a claim. However, for the latter, you will still need to obtain a diagnosis code from your medical provider (primary care physician, chiropractor, etc).

**Usual and Customary Fees**

I am committed to providing exemplary service for which I charge fees that are usual and customary for this area. You are responsible for payment regardless of any person or party’s arbitrary determination of what constitutes usual and customary fees.

**Cancellation and Tardiness Policy**

Appointment charges are not prorated should you be late for a session; THE FULL HOUR CHARGES WILL APPLY.

I REQUIRE 24-HOURS NOTICE FOR ANY APPOINTMENT RESCHEDULING OR CANCELLATION. If you fail to show up for an appointment or make changes with less than 24 hour’s notice, you will be charged for the appointment. Any individual who fails to show or cancels appointments less than 24 hours in advance three times will be referred to another practitioner. We have a wait list of clients who are given priority access to cancelled appointments. Our staff manages rescheduling. Patients may not exchange or switch appointments with other patients independent of our office.

**Returned Checks**

Any check that is returned for any reason will be assessed a fee that is equal to, but not more than, the fee assessed by my bank. A replacement check will not be acceptable restitution. An alternative form of payment of cash, cashier’s check, Visa, MasterCard, American Express or Discover will be required.

I have read and understand the Financial Policy section: \_\_\_\_\_\_\_\_ (Please initial here)

**RIGHTS SECTION**

**Practitioner rights:**

1. I have the right to accurate health history information from you. Optimal treatment follows on the heels of thorough and open communication about health concerns.
2. I have the right to hear about any concerns you may have with the treatment process and our therapeutic relationship. I cannot appropriately address something I do not know is a concern for you.
3. I have the right to courteous treatment free of verbal, physical or sexual abuse.
4. I have a right to terminate any client if that client:
   1. Would better be served by a different provider or modality.
   2. Has been or is verbally abusive to me or any other member of my staff, or sexually harasses me or any member of my staff.
   3. Continuously cancels appointments, is a no show for appointments, or fails to pay for appointments in a timely fashion or as previously agreed.

**Your rights:**

1. You have the right to file a complaint against me with my professional associations.
2. You have the right to be notified in writing of any changes in my fee schedule.
3. You have the right to receive complete and current information concerning the assessment and recommendations I make, including the expected duration of these services.
4. You may expect courteous treatment, free of verbal, physical, or sexual abuse.
5. Your records and transactions are confidential, unless you authorize their release in writing or as otherwise provided by the law.
6. You have the right to choose among available service providers and to change providers after my services have begun, within the limitations of any applicable health insurance medical assistance or other related programs.
7. You have the right to a coordinated transfer if you opt to change service providers.
8. You may refuse the services at any time except as otherwise provided by law.
9. You may assert your rights without any fear of retaliation.

I have read and understand the Rights section: \_\_\_\_\_\_ (Please initial here)

**PHILOSOPHY SECTION**

The following is a description of my philosophy, and what you can expect from me:

**Lactation services**: My role as a lactation consultant is to support your breastfeeding goals, no matter what they may be, in such a way as to promote optimal mental and physical health. I utilize my extensive training in all modalities to nurture this process. There is much misinformation about breastfeeding management provided by many well meaning but ill informed health care practitioners. Part of my role is to help you identify appropriate management strategies and provide you with up-to-date evidence based and theory-based breastfeeding information. It is also my role and my pleasure to serve you and your family throughout the lactation lifecycle, helping you to achieve your breastfeeding goals for as long as you choose to breastfeed.

Any lactation therapy that I initiate when working with you will utilize the least amount of intervention for the shortest period of time. It is my job to ensure that your breastfeeding situation be normalized and become enjoyable and productive as soon as possible. However, you will remain in the “driver’s seat”. I will provide you with information about any and all interventions I plan to initiate but will not proceed without your Informed Consent.

**Craniosacral Therapy**: Health lies within us all, waiting to be mobilized. My role as a therapist is to support and nurture the body’s inherent health utilizing the skills I have learned in my training. These skills can release soft tissue restrictions, optimize the flow of cerebrospinal fluid, blood and lymph, optimize nerve function, increase body awareness, increase relaxation, support the release of emotions generated by ill health, and decrease the symptoms of stress. You can expect me to use my skills and training to the best of my ability to support your goals of health and well-being.

**Massage Therapy:** Massage therapy has innumerable benefits and **may** help with many ailments including, but not limited to, promoting relaxation, reducing stress and anxiety, mitigating symptoms of depression, reduce muscle tension and body aches and pains, reduce pain resulting from fibromyalgia and osteoarthritis, improve cardiovascular health, enhance exercise performance, reduce headaches and migraines, reduce symptoms of lower back pain and carpal tunnel syndrome, lower blood pressure. My job as a massage therapist is to work with you to determine what would be most beneficial for you as my client, develop a treatment plan, and utilize my training as a massage therapist to help you achieve your goals.

I have read and understood the Philosophy section: \_\_\_\_\_ (Please initial here)

**PRIVACY NOTICE**

All uses, disclosures of, or requests for protected health information (PHI) will be limited to the minimum amount necessary to accomplish the stated purpose. Professional judgment will determine the amount of information to be released. The minimum necessary standard is not intended to impede the provision of quality health care.

Disclosures of PHI between providers for treatment, payment and health care operations, or pursuant to an authorization without complying with this requirement are exempt from the minimum necessary rule. Occasionally, providers share details about certain cases for the purpose of educating a student, apprentice, intern, or colleague, or getting input on an aspect of a case for which they require assistance. This sharing of case details preserves anonymity, while demonstrating the utmost respect for the client and their family. *AT NO TIME ARE ANY DETAILS OF A CLIENT-THERAPIST RELATIONSHIP SHARED FOR THE PURPOSE OF BELITTLING OR GOSSIPING ABOUT THAT CLIENT OR THEIR FAMILY. AT NO TIME SHOULD YOU SHARE ANY DETAILS OF THE CLIENT-THERAPIST RELATIONSHIP FOR THE PURPOSES OF BELITTLING OR GOSSIPING ABOUT YOUR THERAPIST. IF YOU HAVE CONCERNS ABOUT YOUR THERAPIST OR YOUR TREATMENT, PLEASE DISCUSS WITH YOUR THERAPIST DIRECTLY OR OUR OFFICE MANAGER SO YOUR CONCERNS MAY BE ADDRESSED.* Please ask me about this if you have questions or concerns.

We occasionally take photographs during lactation therapy sessions for educational purposes. We protect the anonymity of our subjects. If you do not give our office permission to take photographs for the purpose described above, our staff will provide you with an opt-out form to complete and sign.

I have read completely the Client Notification Form and understand my rights, the qualifications of the person providing services, and what I should expect from the provider. I also understand and agree to the financial and cancellation policy.

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Signature of Client Date