

COMPLEMENTARY & ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

Please read this Complementary and Alternative Health Care Client Bill of Rights. I am pleased to provide you with this Client Bill of Rights, in accordance with Minnesota Laws, Statute 146, governing complementary and alternative health care practices.

1. **Name and title:** Judith A. Peterson, Bachelor of Science; Massage Therapist; Myofascial Trigger Point Therapist, Connective Tissue Massage Therapist, Reiki Practitioner, owner of **Muscle Mechanics Inc., D.B.A. Muscle Therapy Mechanics**. My services are available at: **10210 Queen Ave. So, Bloomington, MN 55431. Telephone: 952-881-6559. Email: mtmechanics@comcast.net**

2. **Education and Experience:** The core of my bodywork education came through the two-year certification course from the Bonnie Prudden Academy for Physical Fitness and Myotherapy in Lenox, MA. Following graduation in 1982, I accepted a two-year teaching appointment at the Academy, while continuing to provide services for personal and Academy clinic clients. In the mid-1980's, I co-owned and operated an exercise/massage/myotherapy studio, employing seven instructors. Over the years I have provided periodic therapy for friends and family with muscular dysfunction. In February 1998, I opened my home-based office, **Muscle Mechanics, Inc.** I hold a certificate for 1,800 hours of professional education, and accumulate additional hours of continuing education each calendar year. I am a member of two national organizations and one state organization that are related to my field.

In accordance with the MN State law, I am providing you with the following notice:

“The state of Minnesota has not adopted any educational and training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for informational purposes only. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuation of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, nurse, osteopath, physical therapist, dietician, nutritionist, acupuncture practitioner, athletic trainer, or any type of health care provider, the client may seek such services at any time.”

3. **Supervisor:** As a self-employed practitioner, I do not have a supervisor.

4. **Complaints:** You have the right to file a complaint against me if you are dissatisfied with my services in any way. You may file a complaint without informing me. However, informing me about your complaint is appreciated and, if appropriate, I will schedule a time to discuss the matter with you.

5. **File complaints to Minnesota Dept. of Health:** You may file any complaints that you have with the Office of Unlicensed Complementary and Alternative Health Care Practice, Health Occupations Program, Minnesota Dept. of Health, 121 East Seventh Place Suite 400, P. O. Box 64975, St. Paul, MN 55164-0975. 651-282-6319; 1-800-657-3957; Fax 651-282-5628. Martha.hansen@health.state.mn.us ...or reach her at above phone numbers.

6. **Fees:** \$75.00 per session. Cancellation notice must be received at least 12 hours prior to the appointment time, and a cancellation fee of not more than \$20.00 may be assessed for the missed appointment. Fees are payable at the time of service. If you are unable to pay the full fee at the time of service, a payment plan may be arranged. This plan must be agreed to in writing prior to the provision of services. In order to receive services, you must be current with your payment plan arrangement. *I do not handle insurance claims*; however, a receipt will be provided to you, should you wish to file a claim with your provider. I do not accept Medicare, Medical Assistance or General Assistance medical care.

7. **Change in Service:** You have a right to reasonable notice of changes in services or charges.

8. **Brief Summary of My Theoretical Approach:** The client will enter a safe, clean, calm, and comfortable environment which will aid in producing effective healing, thus assisting the body's innate ability to heal itself. The client's muscular discomforts will be addressed and we will agree on how best to begin the bodywork to relieve the dysfunction. Information will be provided to the client regarding stretches and take-home exercises.
9. **Assessment and Recommendations:** You have the right to receive complete and current information concerning my assessment of your condition based on the information you provide to me and my recommendations for services that I can provide to you, including the expected duration of the services to be provided.
10. **Courteous Service:** You may expect to receive courteous treatment and be free from verbal, physical or sexual abuse by your practitioner.
11. **Confidentiality:** Your records and transactions with this office are confidential, unless release of these records is authorized by you, or otherwise provided by law.
12. **Records:** You are allowed access to records and written information from records in accordance with section 144.335 of Minnesota statutes.
13. **Other Community Services:** Other similar services are available in the community. Possible sources of information are "Minnesota Wellness Directory," "The Edge" newspaper directory, or the telephone "Yellow Pages."
14. **Selecting and Changing Practitioners:** You have the right to choose freely among available practitioners and to change practitioners at any time. If these services are covered by your health insurance, medical assistance plan or other health program, you should direct all questions about coverage to your insurance provider.
15. **Changing Providers:** Should you choose to change providers, you have the right to coordinate transfer of service.
16. **Right to Refuse Service:** You are free to refuse services or treatment unless otherwise provided by law.
17. **No Retaliation:** You may assert your rights described in this Client Bill of Rights at any time without retaliation.

ACKNOWLEDGEMENT

I have received a copy of this Complementary and Alternative Client Bill of Rights. I have read and understood the Client Bill of Rights, or it has otherwise been read to me.

Client name – please PRINT

Relationship to client
(self, parent, or legal guardian)

Signature

Date
