Shabbazz Organics

Organics | Natural | Essential | Vital | Healing

Recovery & Wellness

Referral & Documentation Packet

Provider Referral Form | Client Intake & Consent | Progress Note Template | Pricing & Payment Policy

Shabbazz Organics LLC

525 N. Sam Houston Pkwy E. Suite 521, Houston, TX 77060

Phone: 832-267-4495 | Email: shabbazzorganics@gmail.com | Website: shabbazzorganics.com

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Use these forms for professional referral intake, client consent, visit documentation, payment policies, and wellness compliance records.

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Provider Referral Form

REFERRAL DETAILS

Date of Referral: _____ **Urgency / Priority:** _____

- ☐ Routine
- ☐ Same Week
- ☐ Post-Accident
- ☐ Attorney / PI Case
- ☐ Doctor / Clinic Referral
- ☐ Other

REFERRING PROVIDER / OFFICE / LAW FIRM

Referring Office / Clinic / Law Firm:

_____

Provider / Attorney Name: _____ **Contact Person / Case Manager:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Office Address:

_____

- ☐ Preferred Communication: Phone
- ☐ Preferred Communication: Email
- ☐ Preferred Communication: Fax
- ☐ Client will call
- ☐ Office will schedule

CLIENT INFORMATION

Client Full Name: _____ **Date of Birth:** _____

Phone: _____ **Email:** _____

Client Address:

_____

Emergency Contact: _____ **Emergency Contact Phone:** _____

REFERRAL TYPE / SERVICE REQUESTED

- ☐ Massage Therapy
- ☐ Red Light Table Session
- ☐ Massage Chair Session
- ☐ Inversion Therapy Screening
- ☐ Wellness Recovery Session
- ☐ Post-Accident Soft Tissue Recovery
- ☐ Stress / Tension Relief
- ☐ Mobility / Flexibility Support
- ☐ Other

Primary Complaint / Reason for Referral:

_____

Date of Injury / Accident / Onset: _____ **Case or Claim Number, if applicable:** _____

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Provider Referral Form

- [ ] Auto Accident
- [ ] Work-Related Injury
- [ ] Chronic Pain / Tension
- [ ] Wellness / Preventive Care
- [ ] Slip and Fall
- [ ] Sports Injury
- [ ] Stress-Related Tension
- [ ] Other

AREA(S) OF CONCERN

- [ ] Neck
- [ ] Shoulders
- [ ] Upper Back
- [ ] Mid Back
- [ ] Lower Back
- [ ] Hips
- [ ] Sciatic Area
- [ ] Knees
- [ ] Ankles / Feet
- [ ] Arms / Hands
- [ ] Headache / Tension Area
- [ ] General Full Body
- [ ] Other

- [ ] Side Affected: Left
- [ ] Side Affected: Right
- [ ] Bilateral
- [ ] Central
- [ ] General

SYMPTOMS REPORTED BY CLIENT

- [ ] Muscle tightness
- [ ] Soreness
- [ ] Stiffness
- [ ] Spasms
- [ ] Reduced range of motion
- [ ] Tenderness
- [ ] Fatigue
- [ ] Numbness / tingling
- [ ] Headache tension
- [ ] Stress / anxiety tension
- [ ] Sleep disruption
- [ ] Other

REQUESTED FREQUENCY / DURATION

- [ ] 1 visit
- [ ] 1x weekly
- [ ] 2x weekly
- [ ] 3x weekly
- [ ] As tolerated
- [ ] Re-evaluate after set number of visits
- [ ] Provider discretion
- [ ] Other

- [ ] 15 minutes
- [ ] 20 minutes
- [ ] 30 minutes
- [ ] 45 minutes
- [ ] 60 minutes
- [ ] 90 minutes
- [ ] Provider discretion

MEDICAL CONSIDERATIONS / RESTRICTIONS

Known restrictions, precautions, contraindications, surgeries, implants, blood clots, fractures, skin issues, pregnancy, cardiovascular concerns, active infection, or physician limitations:

- [ ] Client medically cleared: Yes
- [ ] Client medically cleared: No
- [ ] Unknown
- [ ] Clearance recommended before service

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Provider Referral Form

RECORDS / DOCUMENTATION REQUEST

- ☐ Provide visit notes upon signed authorization
- ☐ Provide attendance records
- ☐ Client will request records directly
- ☐ Provide invoices / receipts
- ☐ Provide progress summary after set number of visits
- ☐ Attorney / clinic will request records with authorization

Records Contact Name: _____ **Records Contact Email / Fax:** _____

PAYMENT / CASE HANDLING

- ☐ Client self-pay
- ☐ Attorney Letter of Protection requested
- ☐ Invoice requested
- ☐ Package purchase
- ☐ Insurance-related documentation requested
- ☐ Other

Billing Contact: _____ **Billing Email / Fax:** _____

This referral is for adjunct wellness and recovery services. Shabbazz Organics does not provide diagnosis, emergency care, physical therapy, chiropractic care, pain management, legal case valuation, or medical causation opinions.

Provider / Office Representative Signature: _____

Printed Name: _____ **Date:** _____

COMPLIANCE STATEMENT

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Client Intake & Consent Form

CLIENT INFORMATION

Full Name: _____ **Date of Birth:** _____

Age: _____ **Phone:** _____ **Email:** _____

Address:

_____

Emergency Contact: _____ **Emergency Contact Phone:** _____

☐ Preferred Contact: Phone ☐ Preferred Contact: Text ☐ Preferred Contact: Email

VISIT TYPE / REFERRAL SOURCE

☐ First Visit ☐ Follow-Up Visit ☐ Attorney Referral

☐ Doctor / Clinic Referral ☐ Walk-In ☐ Wellness Client

☐ Post-Accident Recovery ☐ Other

Referred by / Office / Attorney / Provider:

_____

SERVICE REQUESTED

☐ Massage Therapy ☐ Red Light Table Session ☐ Massage Chair Session

☐ Inversion Therapy ☐ Wellness Recovery Session ☐ Combination Session

☐ Other

MAIN REASON FOR VISIT

Please describe what brings you in today:

_____

Date symptoms started: _____ **Accident / Injury Date, if applicable:** _____

☐ Related to accident or injury: Yes ☐ Related to accident or injury: No ☐ Auto accident

☐ Slip and fall ☐ Work injury ☐ Sports injury

☐ Lifting injury ☐ Unknown ☐ Other

PAIN / DISCOMFORT ASSESSMENT

Current discomfort level: 0 = no discomfort, 10 = severe discomfort.

Before Session Pain Level 0-10: _____ **After Session Pain Level 0-10:** _____

Primary Area of Discomfort: _____ **Secondary Area of Discomfort:** _____

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Client Intake & Consent Form

- [ ] Sharp
- [ ] Dull
- [ ] Aching
- [ ] Burning
- [ ] Tight
- [ ] Stiff
- [ ] Tingling
- [ ] Numb
- [ ] Spasm
- [ ] Heavy
- [ ] Radiating
- [ ] Other

What makes it worse?

What makes it better?

BODY AREA CHECKLIST

- [ ] Head / scalp
- [ ] Jaw
- [ ] Neck
- [ ] Shoulders
- [ ] Upper back
- [ ] Mid back
- [ ] Lower back
- [ ] Hips
- [ ] Glutes / sciatic area
- [ ] Chest / ribs
- [ ] Abdomen
- [ ] Arms
- [ ] Elbows
- [ ] Wrists / hands
- [ ] Thighs
- [ ] Knees
- [ ] Calves
- [ ] Ankles / feet
- [ ] Full body tension

HEALTH HISTORY

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Heart condition
- [ ] Diabetes
- [ ] Neuropathy
- [ ] Blood clot history
- [ ] Stroke history
- [ ] Cancer history
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Autoimmune condition
- [ ] Rheumatoid arthritis
- [ ] Osteoporosis
- [ ] Herniated disc
- [ ] Sciatica
- [ ] Recent surgery
- [ ] Recent fracture
- [ ] Skin infection / rash
- [ ] Open wound
- [ ] Varicose veins
- [ ] Pregnancy
- [ ] Pacemaker / implantable device
- [ ] Metal implants
- [ ] Seizure history
- [ ] Light sensitivity
- [ ] Taking blood thinners
- [ ] Taking pain medication
- [ ] Other

Current medications, supplements, pain relievers, muscle relaxers, blood thinners, or topical treatments:

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Client Intake & Consent Form

CONTRAINDICATION SCREENING

Please answer each screening item before services are performed.

- ☐ Fever/contagious illness/infection: Yes
- ☐ Swelling/redness/heat/severe pain: Yes
- ☐ Known or suspected blood clot: Yes
- ☐ Surgery in the last 6 weeks: Yes
- ☐ Open wounds, burns, or active skin lesions: Yes
- ☐ Pregnant or possibly pregnant: Yes
- ☐ Implanted medical device: Yes
- ☐ Sensitive to light or heat: Yes
- ☐ Doctor advised avoid services: Yes

- ☐ Fever/contagious illness/infection: No
- ☐ Swelling/redness/heat/severe pain: No
- ☐ Known or suspected blood clot: No
- ☐ Surgery in the last 6 weeks: No
- ☐ Open wounds, burns, or active skin lesions: No
- ☐ Pregnant or possibly pregnant: No
- ☐ Implanted medical device: No
- ☐ Sensitive to light or heat: No
- ☐ Doctor advised avoid services: No

Explain any Yes answers:

CLIENT CONSENT

I understand that services provided by Shabbazz Organics may include massage therapy, red light table sessions, massage chair sessions, inversion therapy screening, and general wellness recovery services. Massage therapy is performed only by a licensed massage therapist where required. Red light table sessions, massage chair sessions, and other wellness services are not emergency medical services and are not substitutes for medical diagnosis or treatment. I agree to communicate any discomfort, pain, dizziness, numbness, shortness of breath, skin irritation, anxiety, or unusual symptoms before, during, or after my session. I understand that I may stop or modify the session at any time. I understand that results vary and no specific outcome is guaranteed.

Client Initials:

RELEASE OF INFORMATION

I authorize Shabbazz Organics to release attendance records, invoices, session notes, and progress summaries to the authorized party listed below.

- ☐ Referring doctor / clinic
- ☐ Insurance-related representative
- ☐ Referring attorney
- ☐ Other authorized party

Authorized Party Name: **Phone / Fax / Email:**

Client Initials:

PAYMENT RESPONSIBILITY

I understand that I am responsible for payment unless other written arrangements have been approved by Shabbazz Organics.

- ☐ Cash
- ☐ Credit / Debit Card
- ☐ Package
- ☐ Invoice
- ☐ Letter of Protection, if approved
- ☐ Other

Client Initials:

CLIENT SIGNATURE

Client Signature: _____

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Client Intake & Consent Form

Printed Name: _____ **Date:** _____

Staff Witness: _____

COMPLIANCE STATEMENT

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Progress Note Template

CLIENT / CASE INFORMATION

Client Name: _____ **Date of Service:** _____

Visit #: _____ **Date of Birth:** _____ **Case / File #:** _____

Referred By: _____ **Provider / Therapist Name:** _____

License Number, if applicable: _____ **Massage Establishment License #, if applicable:** _____

SERVICE PERFORMED

- ☐ Massage Therapy
- ☐ Red Light Table Session
- ☐ Massage Chair Session
- ☐ Inversion Therapy
- ☐ Wellness Recovery Session
- ☐ Combination Session
- ☐ Other

Session Start Time: _____ **End Time:** _____ **Total Duration:** _____

SUBJECTIVE CLIENT REPORT

Client-reported discomfort before session 0-10: _____ **Client-reported discomfort after session 0-10:** _____

Client main complaint today:

_____

- ☐ Better
- ☐ Worse
- ☐ Same
- ☐ Comes and goes
- ☐ New complaint
- ☐ Unknown
- ☐ Tightness
- ☐ Soreness
- ☐ Stiffness
- ☐ Spasm
- ☐ Aching
- ☐ Burning
- ☐ Tingling
- ☐ Numbness
- ☐ Radiating discomfort
- ☐ Stress tension
- ☐ Fatigue
- ☐ Other

AREA(S) ADDRESSED

- ☐ Neck
- ☐ Shoulders
- ☐ Upper back
- ☐ Mid back
- ☐ Lower back
- ☐ Hips
- ☐ Glutes / sciatic area
- ☐ Legs
- ☐ Arms
- ☐ Feet
- ☐ Full body
- ☐ Other
- ☐ Side: Left
- ☐ Side: Right
- ☐ Bilateral
- ☐ Central
- ☐ General

OBJECTIVE OBSERVATIONS

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Progress Note Template

- [ ] Muscle tension noted
- [ ] Guarded movement
- [ ] Reduced relaxation response
- [ ] Postural tension
- [ ] Limited comfort with positioning
- [ ] Tenderness reported
- [ ] Client tolerated session well
- [ ] Client requested lighter pressure
- [ ] Client requested session modification
- [ ] No unusual response observed
- [ ] Other

Observation notes:

TREATMENT / SESSION DETAILS

- [ ] Pressure: Light
- [ ] Pressure: Medium
- [ ] Pressure: Firm
- [ ] Pressure: Not applicable
- [ ] Relaxation
- [ ] Swedish
- [ ] Light therapeutic massage
- [ ] Myofascial-style work
- [ ] Stretching-assisted comfort work
- [ ] Trigger-point-style comfort work
- [ ] Red light table
- [ ] Massage chair
- [ ] Inversion screening/session
- [ ] Other
- [ ] Position: Face up
- [ ] Position: Face down
- [ ] Side-lying
- [ ] Seated
- [ ] Table
- [ ] Chair
- [ ] Other

Session details / areas avoided / modifications:

CLIENT RESPONSE

- [ ] Relaxed
- [ ] Less tightness reported
- [ ] Less soreness reported
- [ ] Improved comfort reported
- [ ] No change reported
- [ ] Mild soreness reported
- [ ] Session stopped early
- [ ] Referred back to medical provider
- [ ] Other

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Progress Note Template

Client response notes:

PLAN / RECOMMENDATION

- ☐ Continue same service
- ☐ Modify pressure
- ☐ Massage therapy recommended
- ☐ Client advised to follow provider instructions
- ☐ Progress summary recommended after set number of visits
- ☐ Modify duration
- ☐ Red light table recommended
- ☐ Massage chair recommended
- ☐ Client advised to seek medical evaluation for worsening symptoms
- ☐ Other

- ☐ Recommended next visit: 1 week
- ☐ 3x weekly
- ☐ Provider / doctor guidance
- ☐ 2x weekly
- ☐ As needed
- ☐ Other

Additional plan notes:

PROVIDER SIGNATURE

Provider / Therapist Signature: _____

Printed Name: _____ **Date:** _____

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Pricing & Payment Policy

POLICY EFFECTIVE DATE

Effective Date: _____ **Prepared / Updated By:** _____

SERVICES OFFERED

- ☐ Massage Therapy
- ☐ Red Light Table Sessions
- ☐ Massage Chair Sessions
- ☐ Inversion Therapy
- ☐ Wellness Recovery Sessions
- ☐ Combination Sessions
- ☐ Other

Massage therapy services are performed only by properly licensed massage therapy providers where required.

STANDARD PRICING

Enter current service prices below. Leave unused services blank.

Massage Therapy - 15 minutes: $ _____ **Massage Therapy - 30 minutes: $** _____

Massage Therapy - 45 minutes: $ _____ **Massage Therapy - 60 minutes: $** _____

Massage Therapy - 90 minutes: $ _____ **Custom Massage Session: $** _____

Red Light Table - 15 minutes: $ _____ **Red Light Table - 20 minutes: $** _____

Red Light Table - 30 minutes: $ _____ **Custom Red Light Session: $** _____

Massage Chair - 15 minutes: $ _____ **Massage Chair - 30 minutes: $** _____

Inversion Therapy - 15 minutes: $ _____ **Inversion Therapy - 30 minutes: $** _____

Massage + Red Light Combo: $ _____ **Red Light + Massage Chair Combo: $** _____

Custom Combination Price / Notes:

PACKAGE PRICING

3-Visit Package: $ _____ **5-Visit Package: $** _____

10-Visit Package: $ _____ **Monthly Wellness Package: $** _____

Custom Package: $ _____ **Package Expiration Date:** _____

Package terms:

ACCEPTED PAYMENT METHODS

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Pricing & Payment Policy

- ☐ Cash
- ☐ Credit / Debit Card
- ☐ Zelle
- ☐ Cash App
- ☐ Invoice
- ☐ Attorney Letter of Protection, if approved
- ☐ Other

PAYMENT RESPONSIBILITY

Payment is due at the time services are rendered unless a written payment arrangement has been approved in advance. The client is financially responsible for all services received. If a third party, attorney, clinic, or case representative is involved, the client remains responsible for unpaid balances unless Shabbazz Organics has a signed written agreement stating otherwise.

ATTORNEY / PERSONAL INJURY CASE POLICY

Shabbazz Organics may provide visit documentation, attendance records, invoices, and progress notes upon proper written authorization. Acceptance of personal injury clients does not guarantee acceptance of a Letter of Protection. Any Letter of Protection or delayed payment arrangement must be reviewed and approved before services are provided under that arrangement. Shabbazz Organics does not pay referral fees, commissions, gifts, bonuses, or anything of value in exchange for client referrals.

CANCELLATION / NO-SHOW POLICY

Required cancellation notice, hours: _____ **Late cancellation fee: $** _____

No-show fee: $ _____ **Prepayment required after missed visits:** _____

Clients arriving late may receive a shortened session depending on scheduling availability. Full payment may still be required for the originally scheduled service time.

REFUND POLICY

Completed services are non-refundable. Unused prepaid services may be handled according to the selected option below.

- ☐ Store credit
- ☐ Transferable with approval
- ☐ Refundable within set number of days
- ☐ Non-refundable
- ☐ Other written arrangement

Refund / credit notes:

RECORDS FEE POLICY

- ☐ Visit dates
- ☐ Service type
- ☐ Duration
- ☐ Payment history
- ☐ Progress notes
- ☐ Invoices / receipts
- ☐ Attendance summary

Standard records turnaround, business days: _____ **Records fee, if applicable: $** _____

Records policy notes:

CLIENT ACKNOWLEDGMENT

I understand the pricing, payment responsibility, cancellation policy, records policy, and personal injury case policy listed above.

Client Signature: _____

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Staff Witness: _____

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