



For use and/or disclosure of Protected Health Information (PHI)  
To carry out Treatment, Payment and Healthcare Operations

\_\_\_\_\_, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. Rejuvenate, Inc's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for Rejuvenate Inc. to provide treatment to me, and also necessary for Rejuvenate Inc. to obtain payment for that treatment and to carry out it's health care operations. Rejuvenate Inc. explained to me that the Privacy Notice would be available to me in the future at my request. Rejuvenate has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. Rejuvenate, Inc. reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. Rejuvenate's "Notice of Privacy Practices" is also provided in the front lobby. I may also request a copy from this office at any time via US Mail, or email.
4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of Individual (Printed)

\_\_\_\_\_  
Signature of Individual

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness



### Patient Personal/Confidential Data

Date: \_\_\_\_\_ Name: \_\_\_\_\_ What You Prefer To Be Called: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Would you like to subscribe to our email list for all the latest deals at Rejuvenate?  YES  NO

Your Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

How Long At Present Employer? \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Widowed

Would you prefer Phone Calls or Email reminders? \_\_\_\_\_ Phone Number you would prefer: \_\_\_\_\_

### Account Responsibility Information

Name of person ultimately responsible for account:  
\_\_\_\_\_

Relationship to you: \_\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

Payment:  Cash  Check  Credit Card

CC# \_\_\_\_\_ Expires: \_\_\_\_\_ / \_\_\_\_\_

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

### Miscellaneous Information

Emergency Contact Name and Relationship to the Patient:  
\_\_\_\_\_

Phone Number(s): \_\_\_\_\_

Medical Physician's Name: \_\_\_\_\_

Medical Physician's Phone Number: \_\_\_\_\_

Whom May we thank for referring you to our Wellness Center:  
\_\_\_\_\_

Other Family Members seen here:  
\_\_\_\_\_

## Health History

Please list all medications you are currently take (names, amounts, and how often)?

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Have you ever had any of the following diseases/medical condition(s)?

Y N Heart Attack / Stroke	Y N Heart Surg/Pacemaker	Y N Heart Murmur
Y N Congenital Heart Defect	Y N Mitral Valve Prolapsed	Y N Artificial Valves
Y N Alcohol / Drug Abuse	Y N Venereal Disease	Y N Hepatitis
Y N HIV+ / AIDS	Y N Shingles	Y N Cancer
Y N Frequent Neck Pain	Y N Emphysema/Glaucoma	Y N Anemia
Y N High/Low Blood Pressure	Y N Psychiatric Problems	Y N Rheumatic Fever
Y N Severe/Frequent Headaches	Y N Kidney Problems	Y N Ulcers / Colitis
Y N Fainting/Seizures/Epilepsy	Y N Sinus Problems	Y N Asthma
Y N Diabetes/Tuberculosis	Y N Difficulty Breathing	Y N Chemotherapy
Y N Lower Back Pain	Y N Artificial Bones/Joints	Y N Arthritis
Y N Allergies to oils/perfumes	Y N Varicose Veins	Y N Sensitivity to touch/pressure
Y N Whiplash	Y N Open cuts, bruises, burns	Y N Osteoporosis

You primarily sleep on your: side back stomach

Do you wake feeling rested? Y or N

Please list all supplements, vitamins and herbs you are currently taking

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Please list any other serious medical condition(s) you have or ever had:

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Please list anything that you may be allergic to: \_\_\_\_\_

List all previous surgeries/treatments with dates: \_\_\_\_\_

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List any and all accidents with dates: \_\_\_\_\_

Are you wearing:  Heel lifts  Sole lifts  Inner soles  Arch supports

Do you exercise regularly? Yes No

Do you smoke? Yes No If yes, how many per day: \_\_\_\_\_ How long have you been smoking? \_\_\_\_\_

For Women: Are you taking birth control? Y or N Are you pregnant? Y or N Are you nursing? Y or N

Do you feel there are goals to reach in regard to your health? Y or N If yes, Explain: \_\_\_\_\_

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•We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.  
•Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements been made, you will be responsible for any expenses incurred in collecting your account.  
•I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provid to release any information required to process insurance claims.  
•I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

➡Signature \_\_\_\_\_

➡Date \_\_\_/\_\_\_/\_\_\_



### *Reason for Services*

What is your major complaint? \_\_\_\_\_

How did condition develop? \_\_\_\_\_

Date of onset: \_\_\_\_\_ Have you had same or similar problems in the past? \_\_\_\_\_

Is this condition getting worse?     Yes     No     Constant     Comes/Goes

How long has it been since you really felt good? \_\_\_\_\_

What aggravates your condition? \_\_\_\_\_

Does anything offer relief? \_\_\_\_\_

How would you describe your discomfort?     Sharp     Dull     Achy     Throbbing

What percent of the time does this condition bother you?     0%     25%     50%     75%     100%

How would you rate the level of discomfort on a scale of 0 - 10? (0=no pain 10=extreme pain)? \_\_\_\_\_

Have you had previous chiropractic care? Y or N

Have you been treated by others for this condition? Y or N

If yes, please list \_\_\_\_\_

### *For Office Use Only*



## Cancellation Policy

In an effort to reduce the amount of cancellations and no-shows at our facility, we are implementing the following cancellation policy.

Out of common courtesy to other customers and to our contract employees, please do your very best to be respectful of the time you reserve. We do our best to make reminder calls, however, the appointments you make are your responsibility. All appointments missed or not cancelled within 24 hours are subject to the following:

Psychology-24 hour Notice Required  
-\$45 for all sessions

Massage-24 Notice Required  
-\$35 for 60 Min  
-\$50 for 90 Min  
-Gift certificates will be forfeited  
-Credits on accounts will be used for no shows and failure to cancel

Chiropractic-No Show/Failure to Cancel  
-\$30

If there is a pattern of no-show/failure to cancel, it is up to the discretion of the service provider whether to continue to schedule further appointments. By signing this document you agree to the above terms.

\_\_\_\_\_  
Patient/Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date