



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

Are you taking any of the following medications? Please circle all that apply:

Nerve pills    Pain Killers    Muscle relaxers    Stimulants    Blood Thinners    Tranquilizers    Insulin

Other(s): \_\_\_\_\_

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

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: \_\_\_\_\_

- 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 \_\_\_/\_\_\_/\_\_\_

What are your goals/expectations for this therapy session:

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The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:

- Need to move or change position
- Sighing
- Yawning
- Stomach gurgling
- Change in breathing
- Emotional feelings
- Emotional expression
- Memories
- Energy shifts
- Falling asleep
- Movement of Intestinal gas

Are you wearing:

Contact Lenses

Hearing Aid

Hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:



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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date



## Fee Schedule

### Massage 60 minutes

Swedish	\$65
Deep Tissue	\$70
Trigger Point Therapy	\$70
Medical Massage	\$70
Integrative Massage	\$70
Acupressure	\$70
Sports	\$75
Pregnancy	\$75
Reflexology	\$75

### Massage 30 Minutes

All \$65 would be	\$35
All \$70 would be	\$45
All \$75 would be	\$45

### Massage 90 minutes

All \$65 would be	\$97.50
All \$70 would be	\$105
All \$75 would be	\$112.50

### Massage Packages

**Buy 4, get 1 FREE!!**

Swedish	\$260
All \$70	\$280
All \$75	\$300

### Dietitian Services

30-min consultation	\$50
60- min consultation	\$80
5 sessions (30-min)	\$200
10 sessions (30-min)	\$350

### r-Studio Classes

Walk In Class	\$13
5 Class Pass	\$65
10 Class Pass	\$115
20 Class Pass	\$210

### r-Studio Memberships

Unlimited Classes	\$75 per month
Unlimited Family Classes**	\$100 per month
Unlimited Classes + 2 massage*	\$180
Unlimited Classes + 4 massage*	\$275
Unlimited classes + 4 dietitian meetings per month	\$250

- Massages associated with memberships are 1 Hr Swedish massages. If you are interested in a different 1 Hr massage, as additional \$10 charge will apply.

\*\* Family pass includes 2 family members. Any additional family members, under the age of 24, will add an additional \$15 to the total cost of the membership per month.

#### Acknowledgements and Consents

- I understand that the hourly rates listed above are payable at the time of service.

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_



## 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