



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 Information

Food Allergies:

Do you have any GI problems? If so, please explain:

Are you suffering from any medical conditions that affect your eating habits? If so, please explain:

Do you currently have or have any family history of diabetes, heart disease, high blood pressure or any metabolic conditions?

Weight Change:

_____ lbs. (lost/gained) over _____ weeks/months

➡ 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

Dietitian Services

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

Massage 30 Minutes

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

r-Studio Classes

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

Massage 90 minutes

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

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

Massage Packages

Buy 4, get 1 FREE!!

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

- 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.

ATTENTION: ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.

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