



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:



Reason for Services

Please list the reasons for seeking services: _____

Depression

- Sadness
- Crying Episodes
- Worthlessness
- Hopelessness
- Suicidal Thinking
- Loss of Pleasure
- Insomnia
- Sleeping Too Much
- Fatigue
- Excessive Guilt
- Low Self - Esteem

Anxiety

- Panic
- Phobia
- Social Phobia
- Exposure to Trauma
- Restlessness
- Easily Fatigued
- Difficulty Concentrating
- Irritability
- Muscle Tension
- Sleep Disturbance
- Internal Agitation

Anger

- Easily Frustrated
- Annoyed
- Yelling / Screaming / Ranting
- Physical Violence
- Destruction of Property
- Feeling Time Pressured
- Impatience
- Tension
- Thoughts of Revenge
- Excessively Defensive
- Hostility

Health History

Current Medical Problems:

Current Medications (Prescription and Over the Counter):

Medication Allergies: _____

Do you consume alcohol? Yes No If yes, what kind? _____

How much alcohol do you use on a weekly basis? _____ Monthly? _____

How many years have you used alcohol? _____ Do you binge drink? Y / N

Are you concerned with the amount of alcohol you use? Y / N

Do you currently use any "street" drugs? Yes No If yes what kind? _____

Do you currently use any tobacco products? Yes No If yes, what kind? _____

I agree to allow Rejuvenate to collaborate with my Primary Care Physician for medicine management: Yes No

- 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.
- 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 ____/____/____



Consent For Psychological Evaluation

You have been referred by:

to participate in a psychological evaluation. The goal of this evaluation is to provide information about how you are functioning psychologically to the individual or agency requesting the evaluation.

The evaluation itself consists of two separate parts: an oral interview and psychological testing. If the evaluation is paid for by the referral agency you may have access to the information and feedback. If this evaluation is paid for by a referral agency and you want a copy of your evaluation, you must obtain the copy from the referral agency.

Your participation in this evaluation is voluntary. The evaluation will not be performed without your signature on this document. You also have the right to stop the evaluation at any time.

Once you have completed the evaluation, a report will be sent to the above referral agency to aid in their determination of services being requested.

By my signature below, I signify that:

I have had explanation and/or have read and understand the concepts and conditions of informed consent.

I have been given the opportunity to discuss these concepts and conditions and to ask for clarification of parts that I was concerned about or did not understand.

I acknowledge that I have received a copy of Rejuvenate, Inc.'s Notice of Health Information Practices and Rights.

Patient / Parent / Guardian

Date

Witness

Date



Fee Schedule

Psychotherapy

Assessment		\$200
Therapy	20 min	\$75
Therapy	45 min	\$150
Therapy	90 min	\$200
Family	45 min	\$180
Marital	45 min	\$125
Group	60 min	\$50
Group	90 min	\$75
Heartmath*	30 min	\$25
Consultation*	60 min	\$150
Testifying *	60 min	\$150
ADHD Assessment		\$500
Psychological Testing		\$600
Letter Writing*		\$20
Record Request*		\$25
Fee per page		\$.47
Bariatric Evaluation		\$800
Cash Rate		\$375

*Not covered by insurance-responsibility of patient

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.
- I agree to pay Rejuvenate any outstanding bills that have been denied by my insurance company, and I am aware that uncollected bills over 90 days past due will be sent to a collection agency, and/or legal action may be taken.
- I agree to pay Rejuvenate any deductible amounts and any copayments that may be affiliated with my insurance plan.
- It is my responsibility to inform Rejuvenate of any changes in insurance benefits. If services are rendered during a time of non-coverage, I understand that I am responsible for full payment of services

Patient/Parent or Guardian Signature

Date

Witness Signature

Date



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