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 Mind Body Wellness Center'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 to provide treatment to me, and also necessary for Rejuvenate to obtain payment for that treatment and to carry out it's health care operations. Rejuvenate 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 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 Parent/Guardian Date Signed

_____
Witness

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Patient Personal/Confidential Data

Date | Name | Preferred Name

Street Address | City/State/Zip Code

Home Phone Number | Cell Phone Number | Email Address

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

Date of Birth | Age | Social Security Number

Employer Name and Address

Work Phone Number | Occupation | Years at Current Employer

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Would You Prefer Phone Calls or Email Reminders | Phone Number You Would Prefer

Name of Person Ultimately Responsible For Account | Relationship To You

Account Responsibility's SSN | Date Of Birth | Address, City, State, Zip Code

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

Emergency Contact Name | Relationship to the Patient | Phone Number

Medical Physician's Name | Medical Physician's Phone Number

Whom May We Thank For Referring You | Other Family Members Seen Here

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_____
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

How would you describe the condition? □ Constant □ Comes and 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? □ Yes □ No

Have you been treated by others for this condition? □ Yes □ No

If yes, please list:_____

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Health History

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

_____

Please check all the following health conditions that apply:

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

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

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

_____
List all previous surgeries/treatments with dates

_____
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?_____

Women: Are you taking birth control? □ Yes □ No Are you pregnant? □ Yes □ No Are you nursing? □ Yes □ No

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.
▪I authorize the staff to perform any necessary services needed during diagnosis and treatment.
▪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___/___/___

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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 remind you of your appointment, 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 Hour Notice Required
-$35 for 30 or 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 for all appointment types

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