rejuvenate
MIND-BODY WELLNESS CENTER

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

Parent/Legal Guardian Information □ Same as mother's information

Child's Name: _____

Mother: _____	Father: _____
Address: _____	Address: _____
City: _____	City: _____
State and Zip Code: _____	State and Zip Code: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____
Email: _____	Email: _____

Patient resides with: _____ Custody arrangement: _____

Names of stepparents, if necessary: _____

Primary Care Physician/Practice:_____

Insurance Holder:_____ Relationship To Patient: _____

Insurance Holder SSN: _____ Insurance Holder DOB: _____

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

Person responsible for payment on account: _____

SSN: _____ DOB: _____

How did you hear about Rejuvenate: (circle one)

Internet School Doctor Friend Ins/EAP Referred

Whom May We Thank For Referring You: _____

Would you like to subscribe to our email list for all the latest deals at Rejuvenate? □YES □NO
Email address to add: _____
For what are you seeking help with today?

_____

Presenting Problems (check all that apply within the last 6 months):

___ Temper outbursts	___ Impulsive	___Shy
___Withdrawn	___Stubborn	___Strange behavior
___Daydreaming	___Disobedient	___Stealing
___Fearful	___Infantile	___Lying
___Clumsy	___Mean to others	___School Trouble
___Overactive	___Destructive	___Bowel/bladder control
___Short attention span	___Bed wetting	___Feeding/eating problems
___Distractible	___Self-Mutilating	___Sleeping Problems
___Peer conflict	___Head banging	___Drug/Alcohol use
___Phobic/fears	___Rocking	___Sexual acting out
___Fire play	___ Runs away	___Target of bullying
___ Cruelty to animals	___ Physical Complaints	

___ Other: _____

MEDICAL HISTORY

Has the child ever been hospitalized for illness, physical ailments, emotional issues, etc.? Y__N__
If yes, please explain where, when, and what for? _____
_____
_____

Has the child ever taken, or is he/she currently taking any medications? Y___ N___
If yes, please list medication name and frequency of dosage and prescribing doctor's name.
_____
_____

Does the child have any allergies that you are aware of (i.e. latex, peanut, soy, etc.)? _____
_____

LIVING ARRANGEMENTS

Number of moves in child's life____ Ever placed or lived away from family? Y__ N__
Explain: _____

List all members of your household presently and indicate their relation to the child: _____
_____

Describe discipline style used in home:

_____

DEVELOPMENTAL HISTORY

Did mother have any illness or complications before delivery? Y__ N__ If yes, please explain:

_____

_____

Complications at birth? (Explain) _____

Did mother abuse alcohol or drugs during pregnancy? Y__ N__

Length of pregnancy: _____ Full Term? Y__ N__ Birth Weight _____lbs _____oz

As far as you know, did the child meet developmental milestones at an appropriate age (i.e. rolling over, sitting up, babbling, and eating)? Y__ N__ If no, please explain:

_____

_____

Describe any stressful or traumatic experiences that the child may have experienced in his/her life:

_____

_____

EDUCATIONAL HISTORY

Name of School/Daycare_____ Grade: _____

Types of classes: ____Regular ____Inclusion ____ EDB (Emotionally Disturbed Behavior)

____ Other (explain):_____

Does the child receive special services at school? Y__ N__ If yes, please describe below with frequency and duration of each.

_____

Describe any struggles or strengths with school:_____

SOCIAL HISTORY

List any activities that your child participate in _____

_____

How does your child get along with other children his/her age?

_____

➡ Signature (Patient or Guardian)_____ ➡ Date_____/_____/_____

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

Acknowledgements and Consents

- I understand that the cost of services are payable at the time the service is rendered.
- 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
- It is my responsibility to understand my insurance limitations. Rejuvenate will discuss costs and verify benefits as a service to me, however, any services that are rendered as a part of my care are ultimately my responsibility.

In an effort to reduce the amount of cancellations and no-shows at our facility, we abide by 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

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Therapy with Minors

Confidentiality

As a therapist, I believe in providing a child/teen with a private environment in which to disclose himself/herself to facilitate therapy. It is important for a child/teen to trust the therapist in order for therapy to be effective. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. As your child/teen's therapist, I will share general information about progress but will refrain from revealing any specific information shared by your child/teen unless your child/teen consents to it. My hope is to support your child/teen in facilitating these conversations to promote open, clear, supportive communication within your family. *When there is a safety risk assessed, I will share information with you as required by law.*

Your child/teen may wish to share about a therapy session but please be aware not to solicit or put any pressure on your child/teen to share information as this will impact our "zone of privacy".

Family Involvement

In my work with children/teens, I believe the family unit is so important. As part of our treatment, I may ask to include the family in therapy when appropriate. These sessions will support overall goals related to the family. Some family sessions may include only the parents to discuss parenting practices or strategies to support your child/teen's development. Recommendations may be made to make changes in the family unit in order to support changes in your child/teen.

Something that may come up during therapy with children and teens is disagreement between parents regarding the best interests of the child/teen. As parents, it is important for you to be as united as possible to fully support your child/teen in therapy, and it can be difficult for children/teens to be caught between the disagreements of their parents. Thus, if such disagreements occur, I will listen carefully to your concerns and I will attempt to help you find an acceptable resolution. You can choose to resolve such disagreements or you can agree to disagree, so long as this enables your child's therapeutic progress.

Termination

The opportunity to celebrate the completion of treatment goals is important in the life of your child/teen. As part of the termination process, I will plan a celebration session with your child/teen in order to acknowledge progress and growth and to review helpful ongoing strategies.

If at any time you choose to discontinue therapy for any reason, I will share with you my perspectives on your child/teen's needs given what we have worked on in therapy, and I will offer you any appropriate resources or referrals. I ask that you allow me the option of having a closing session(s) to appropriately end the treatment relationship.

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Additional Information Regarding Services With Minor Clients:

Because my role is that of the child's helper, I will not become involved in legal disputes or other official proceedings unless compelled to do so by a court of law. Matters involving custody and mediation are best handled by another professional who is specially trained in those areas rather than by the child's therapist.

If either parent decides that therapy should end, then the therapy must stop. I ask that you inform me ahead of time that you are considering stopping therapy, and allow me the option of having a closing session(s) to appropriately end the treatment relationship.

_____ _____

Parent / Guardian Signature Date