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

rejuvenate
MIND-BODY WELLNESS CENTER

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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MIND-BODY WELLNESS CENTER

For what reasons are you seeking services? Please list below:

____

____

Please check below if you are experiencing any of the following symptoms:

- □ Sadness
- □ Crying Episodes
- □ Worthlessness
- □ Hopelessness
- □ Suicidal Thinking
- □ Loss of Pleasure
- □ Insomnia
- □ Sleeping Too Much
- □ Fatigue
- □ Excessive Guilt
- □ Low Self–Esteem
- □ Panic
- □ Phobia
- □ Social Phobia
- □ Exposure to Trauma
- □ Restlessness
- □ Easily Fatigued
- □ Difficulty Concentrating
- □ Irritability
- □ Muscle Tension
- □ Sleep Disturbance
- □ Internal Agitation
- □ 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):____

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? □ Yes □ No

Are you concerned with the amount of alcohol you use? □ Yes □ No

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? __________________

Would you allow Rejuvenate to collaborate with your 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_____/_____/_____

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

Chiropractic-No Show/Failure to Cancel
-$30 for all appointment types

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

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