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 (Rejuvenate) 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 Mind Body Wellness Center to provide treatment to me, and also necessary for Rejuvenate Mind Body Wellness Center 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 Mind Body Wellness Center 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 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

____
Patient 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, Text Message 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

Health History

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

___

Please check all the following health conditions that apply:

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

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

___

Please list anything that you may be allergic to

___

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.

➡Patient/Parent or Guardian Signature_____________________________________ ➡Date___/___/___

rejuvenate
MIND-BODY WELLNESS CENTER

What are your goals/expectations for this therapy session:
____
____
____
____

The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to.

- Yawning
- Change in breathing
- Emotional expression
- Energy shifts
- Movement of Intestinal gas
- Stomach gurgling
- Emotional feelings
- Memories
- Falling asleep

Are you wearing:
__ Contact Lenses __ Hearing Aid __ Hairpiece

Please indicate with an (X), if any, the areas in which you are feeling discomfort:

______________________________________ ______________
Patient / Parent or Guardian Signature Date

______________________________________ ______________
Witness Signature Date

Fee Schedule

Massage	30 minutes	60 minutes	90 minutes
Swedish	$35	$65	$97.50
Deep Tissue	$45	$70	$105
Trigger Point Therapy	$45	$70	$105
Medical Massage	$45	$70	$105
Integrative Massage	$45	$70	$105
Sports	$45	$75	$112.50
Pregnancy	$45	$75	$112.50
Hot Stone	---	---	$120

Additions: Essential Oil $5

Massage Membership: $50 re-initiation fee will apply if cancelled and reinstated within 12 months.

	1 massage/month	2 per month	3 per month	4 per month
Tier 1 (Swedish)	$49.99	$94.98	$134.97	$169.96
Tier 2 (Any Massage)	$59.99	$114.98	$164.97	$209.96
Tier 3 (Any Mass + Addition)	$64.99	$124.98	$179.97	$229.96

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 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