



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:

Health History

Are you taking any of the following medications? Please circle all that apply:

Nerve pills Pain Killers Muscle relaxers Stimulants Blood Thinners Tranquilizers Insulin

Other(s): _____

Have you ever had any of the following diseases/medical condition(s)?

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

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

For Women: Are you taking birth control? Y or N Are you pregnant? Y or N Are you nursing? Y or N

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.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provid to release any information required to process insurance claims.
- 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 ___/___/___

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:

- Need to move or change position
- Sighing
- Yawning
- Stomach gurgling
- Change in breathing
- Emotional feelings
- Emotional expression
- Memories
- Energy shifts
- Falling asleep
- Movement of Intestinal gas

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 60 minutes**

Swedish	\$65
Deep Tissue	\$70
Trigger Point Therapy	\$70
Medical Massage	\$70
Integrative Massage	\$70
Acupressure	\$70
Sports	\$75
Pregnancy	\$75
Reflexology	\$75

Dietitian Services

30-min consultation	\$50
60- min consultation	\$80
5 sessions (30-min)	\$200
10 sessions (30-min)	\$350

Massage 30 Minutes**

All \$65 would be	\$35
All \$70 would be	\$45
All \$75 would be	\$45

r-Studio Classes

Walk In Class	\$13
10 Class Pass	\$115
20 Class Pass	\$210

Massage 90 minutes**

All \$65 would be	\$97.50
All \$70 would be	\$105
All \$75 would be	\$112.50

r-Studio Memberships

Unlimited Classes	\$75 per month
Unlimited Classes + 2 massage*	\$180
Unlimited Classes + 4 massage*	\$275
Unlimited classes + 4 dietitian meetings per month	\$250

Massage Packages Buy 4, get 1 FREE!!

Swedish	\$260
All \$70	\$280
All \$75	\$300

****No-Show / Failure to cancel within 24 hours \$45 For all sessions 45 minutes or longer OR \$20 or 30 min session**

****If there is a pattern of No-Show/Failure to cancel within 24 hours, it is up to the discretion of the service provider whether to continue to schedule the patient or not.**

*** Massages associated with memberships are 1 Hr Swedish massages. If you are interested in a different 1 Hr massage, as additional \$10 charge will apply.**

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.

Patient / Parent or Guardian Signature

Date

Witness Signature