



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 Information

Food Allergies:

Do you have any GI problems? If so, please explain:

Are you suffering from any medical conditions that affect your eating habits? If so, please explain:

Do you currently have or have any family history of diabetes, heart disease, high blood pressure or any metabolic conditions?

Weight Change:

_____ lbs. (lost/gained) over _____ weeks/months

➡ Signature _____

➡ Date ____/____/____



Consent For Psychological Evaluation

You have been referred by:

to participate in a psychological evaluation. The goal of this evaluation is to provide information about how you are functioning psychologically to the individual or agency requesting the evaluation.

The evaluation itself consists of two separate parts: an oral interview and psychological testing. If the evaluation is paid for by the referral agency you may have access to the information and feedback. If this evaluation is paid for by a referral agency and you want a copy of your evaluation, you must obtain the copy from the referral agency.

Your participation in this evaluation is voluntary. The evaluation will not be performed without your signature on this document. You also have the right to stop the evaluation at any time.

Once you have completed the evaluation, a report will be sent to the above referral agency to aid in their determination of services being requested.

By my signature below, I signify that:

I have had explanation and/or have read and understand the concepts and conditions of informed consent.

I have been given the opportunity to discuss these concepts and conditions and to ask for clarification of parts that I was concerned about or did not understand.

I acknowledge that I have received a copy of Rejuvenate, Inc.'s Notice of Health Information Practices and Rights.

Patient / Parent / Guardian

Date

Witness

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

Massage 30 Minutes**

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

Massage 90 minutes**

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

Massage Packages

Buy 4, get 1 FREE!!

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

Dietitian Services

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

r-Studio Classes

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

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

****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
