



Wellness Doctor, Inc.

61555 Parrell Rd. Bend, OR 97702

P: 541-318-1000 \* F: 541-318-7050 \* E: Appointments@BendWellnessDoctor.com

**\*Remember to bring completed paperwork: (If paperwork is not completed, arrive 30 min prior to appt.)**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: \_\_\_M \_\_\_F \_\_\_Trans Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_S \_\_\_M \_\_\_W \_\_\_D \_\_\_P

Cell Phone: \_\_\_\_\_ Cell phone carrier (for appt text reminders): \_\_\_\_\_

E-mail: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Who may we thank for your referral? \_\_\_\_\_

### PRIMARY INSURED INFORMATION

**If you are the primary insured, mark "self" and move down to "Payment Information".**

**Primary insured:**  Self  Spouse  Parent  Other: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Gender: M F DOB: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

### PAYMENT INFORMATION

Please check the following payment methods that apply:  Cash (Time of Service)  Health Insurance

Workers Compensation  Auto Insurance (auto injury) Date of auto injury/accident: \_\_\_\_\_

#### Cancellation and No-Show Policy

Scheduling an appointment reserves this time especially for you and no one else. Therefore, our office requires 24 hours' notice to cancel an appointment. If 24 hours is not given, a charge of \$25 will be billed to your account.

If you do not show up for your appointment, you will be responsible for a \$25 no show fee. Patients that cancel 24 hours before their scheduled appointment or whose appointment needed to be rescheduled by our office will NOT be subject to a cancellation fee. Thank you, in advance, for giving us 24 hours' notice.

#### Inclement Weather Policy

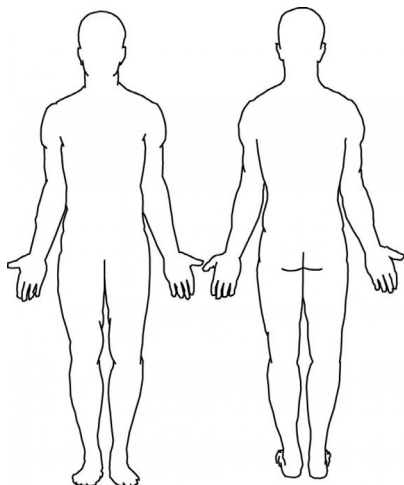
Please be aware of the local forecast and if you feel that you are unable to come in for your scheduled appointment make sure to cancel 24 hours before. The above policies will be applied.

If we close the office due to weather, you will receive a text or phone call from our reception staff and a cancellation fee will not be applied.

**Signature of Patient or Responsible Party** \_\_\_\_\_



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### SYMPTOM SURVEY

1. What is your **Primary** complaint? \_\_\_\_\_
2. Was there trauma or a known cause?  YES  NO  
 If yes, describe: \_\_\_\_\_
3. When did your symptoms begin? \_\_\_\_\_
4. How often do the symptoms bother you?  
 Constant  Frequent  Intermittent  Occasional
5. Has this condition bothered you before?  YES  NO
6. Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER:** \_\_\_\_\_
7. How severe is your pain/discomfort from **0 (none) to 10 (worst imaginable)**? \_\_\_\_\_
8. What makes it worse? \_\_\_\_\_ What relieves it? \_\_\_\_\_
9. Any other symptoms associated with this complaint? \_\_\_\_\_
10. Treated for this in the past?  YES  NO When? \_\_\_\_\_ Where? \_\_\_\_\_

**Problem #2** \_\_\_\_\_ Was there trauma or a known cause?  YES  NO

If yes, describe: \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

How often do the symptoms bother you?  Constant  Frequent  Intermittent  Occasional

Has this condition bothered you before?  YES  NO

Would you describe it as (circle all that apply): **SHARP, SHOOTING, ACHY, ELECTRICAL, DEEP, DULL, ACHING, STIFF, THROBBING, NUMBNESS, TINGLING, CRAMPING, OTHER** \_\_\_\_\_

Where is your pain/discomfort from 0 (*none*) to 10 (*worst imaginable*)? \_\_\_\_\_

What makes it worse? \_\_\_\_\_ What relieves it? \_\_\_\_\_

Any other symptoms associated with this complaint? \_\_\_\_\_

Treated for this in the past?  YES  NO When? \_\_\_\_\_ Where? \_\_\_\_\_

**Problem #3** \_\_\_\_\_ **Problem #4** \_\_\_\_\_

#### Special Imaging and/or Tests (MRI, CT, X-Ray, etc):

Year: \_\_\_\_\_ Test: \_\_\_\_\_ Findings: \_\_\_\_\_

Year: \_\_\_\_\_ Test: \_\_\_\_\_ Findings: \_\_\_\_\_

Year: \_\_\_\_\_ Test: \_\_\_\_\_ Findings: \_\_\_\_\_

**Other:** \_\_\_\_\_

|  |  |
|--|--|
| <p><b>What do your DAILY ACTIVITIES consist of?</b></p> <p><input type="checkbox"/> Heavy Labor                      <input type="checkbox"/> Prolonged Sitting</p> <p><input type="checkbox"/> Light Labor                         <input type="checkbox"/> Prolonged Standing</p> <p><input type="checkbox"/> Repetitive Movements   <input type="checkbox"/> High Mental Stress</p> | <p><b>Do you EXERCISE on a regular basis?</b>   <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How often? _____ How long? _____</p> <p>What types? _____</p> <p><b>Do you SLEEP WELL at night?</b>   <input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|--|--|



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## MEDICAL HISTORY

### Past or Present Concerns:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Irritable Bowel Syndrome              |
| <input type="checkbox"/> Allergies/Hay Fever/Asthma | <input type="checkbox"/> Diverticulitis                    | <input type="checkbox"/> Kidney or Bladder Disease             |
| <input type="checkbox"/> Alcoholism                 | <input type="checkbox"/> Drug Addiction                    | <input type="checkbox"/> Liver or Gallbladder Disease (stones) |
| <input type="checkbox"/> Alzheimer's/Dementia       | <input type="checkbox"/> Eating Disorder _____             | <input type="checkbox"/> Lyme Disease                          |
| <input type="checkbox"/> Autoimmune _____           | <input type="checkbox"/> Epilepsy                          | <input type="checkbox"/> Seasonal Affective Disorder           |
| <input type="checkbox"/> Blood Pressure problems    | <input type="checkbox"/> Emphysema                         | <input type="checkbox"/> Migraine Headaches                    |
| <input type="checkbox"/> Bronchitis                 | <input type="checkbox"/> Eyes, Ears, Nose, Throat problems | <input type="checkbox"/> Neurological Problems _____           |
| <input type="checkbox"/> Cancer _____               | <input type="checkbox"/> Environmental Sensitivities       | <input type="checkbox"/> Obesity                               |
| <input type="checkbox"/> Carpal Tunnel Syndrome     | <input type="checkbox"/> Fibromyalgia                      | <input type="checkbox"/> Osteoporosis                          |
| <input type="checkbox"/> Celiac Disease             | <input type="checkbox"/> Food Intolerance _____            | <input type="checkbox"/> Pneumonia                             |
| <input type="checkbox"/> Chronic Fatigue Syndrome   | <input type="checkbox"/> Gastroesophageal Reflux Disease   | <input type="checkbox"/> Migraine Headaches                    |
| <input type="checkbox"/> Cholesterol, High          | <input type="checkbox"/> Genetic Disorder _____            | <input type="checkbox"/> Skin problems                         |
| <input type="checkbox"/> Circulatory Problems       | <input type="checkbox"/> Glaucoma                          | <input type="checkbox"/> Sinus problems                        |
| <input type="checkbox"/> Colitis                    | <input type="checkbox"/> Gout                              | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Contact Lenses             | <input type="checkbox"/> Heart Disease                     | <input type="checkbox"/> Thyroid problems                      |
| <input type="checkbox"/> Dental problems            | <input type="checkbox"/> Infection, Chronic                | <input type="checkbox"/> Ulcer                                 |
| <input type="checkbox"/> Depression                 | <input type="checkbox"/> Inflammatory Bowel Disease        | <input type="checkbox"/> OTHER _____                           |

### Medical (Men)

- Benign Prostatic Hyperplasia
- Prostate Cancer
- Decreased Sex Drive
- Infertility
- Sexually Transmitted Disease
- OTHER \_\_\_\_\_

### Medical (Women)

- |   |  |
|---|--|
| <input type="checkbox"/> Menstrual Irregularities | <input type="checkbox"/> Pelvic Inflammatory Disease |
| <input type="checkbox"/> Endometriosis            | <input type="checkbox"/> Vaginal Infections          |
| <input type="checkbox"/> Infertility              | <input type="checkbox"/> Decreased Sex Drive         |
| <input type="checkbox"/> Fibrocystic Breasts      | <input type="checkbox"/> C-Section                   |
| <input type="checkbox"/> Fibroids/Ovarian Cysts   | <input type="checkbox"/> Menopause                   |
| <input type="checkbox"/> Premenstrual Syndrome    | <input type="checkbox"/> Breast Cancer               |

### Family Health History- Parents/Grandparents/Siblings:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Autoimmune           | <input type="checkbox"/> Eating Disorder _____        | <input type="checkbox"/> Obesity        |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Genetic Disorder             | <input type="checkbox"/> Osteoporosis   |
| <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Heart Disease                | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Celiac Disease       | <input type="checkbox"/> Cancer _____                 | <input type="checkbox"/> Diabetes       |
| <input type="checkbox"/> Migraine Headaches   | <input type="checkbox"/> Neurological Disorders _____ |   |

### Medications/Supplements

| Med/Sup | Dosage | Reason |
|---------|--------|--------|
|         |        |        |
|         |        |        |
|         |        |        |
|         |        |        |
|         |        |        |
|         |        |        |
|         |        |        |
|         |        |        |

### Traumatic Injury/Surgery

| Year | Trauma/Surgery |
|------|----------------|
|      |                |
|      |                |
|      |                |
|      |                |

Do you have a **Primary Care Provider**?  YES  NO  
 When was your **Last Physical**? \_\_\_\_\_



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### MSQ -MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

|                    |   |   |
|--------------------|---|---|
| <b>Point Scale</b> | <b>0</b> - Never or almost never have the symptom     | <b>3</b> - Frequently have it, effect is not severe |
|                    | <b>1</b> - Occasionally have it, effect is not severe | <b>4</b> - Frequently have it, effect is severe     |
|                    | <b>2</b> - Occasionally have it, effect is severe     |   |

|   |  |
|---|--|
| <b>Head</b><br><input type="checkbox"/> Headaches<br><input type="checkbox"/> Faintness<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> <b>TOTAL</b>   | <b>Digestive Tract</b><br><input type="checkbox"/> Nausea, vomiting<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Bloating feeling<br><input type="checkbox"/> Belching, passing gas<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Intestinal/stomach pain<br><input type="checkbox"/> <b>TOTAL</b>                                |
| <b>Eyes</b><br><input type="checkbox"/> Watery or itchy eyes<br><input type="checkbox"/> Swollen, reddened or sticky eyelids<br><input type="checkbox"/> Bag or dark circles under eyes<br><input type="checkbox"/> Blurred or tunnel vision<br>(does not include near or far-sightedness)<br><input type="checkbox"/> <b>TOTAL</b>                         | <b>Joints/Muscle</b><br><input type="checkbox"/> Pain or aches in joints<br><input type="checkbox"/> Arthritis<br><input type="checkbox"/> Stiffness or limitation of movement<br><input type="checkbox"/> Pain or aches in muscles<br><input type="checkbox"/> Feeling of weakness or tiredness<br><input type="checkbox"/> <b>TOTAL</b>  |
| <b>Ears</b><br><input type="checkbox"/> Itchy Ears<br><input type="checkbox"/> Earaches, ear infections<br><input type="checkbox"/> Drainage from ear<br><input type="checkbox"/> Ringing in ears, hearing loss<br><input type="checkbox"/> <b>TOTAL</b>  | <b>Weight</b><br><input type="checkbox"/> Binge eating/drinking<br><input type="checkbox"/> Craving certain foods<br><input type="checkbox"/> Excessive weight<br><input type="checkbox"/> Compulsive eating<br><input type="checkbox"/> Water retention<br><input type="checkbox"/> Underweight<br><input type="checkbox"/> <b>TOTAL</b>  |
| <b>Nose</b><br><input type="checkbox"/> Stuffy Nose<br><input type="checkbox"/> Sinus problems<br><input type="checkbox"/> Hay fever<br><input type="checkbox"/> Sneezing attacks<br><input type="checkbox"/> Excessive mucus formation<br><input type="checkbox"/> <b>TOTAL</b>  | <b>Energy/Activity</b><br><input type="checkbox"/> Fatigue, sluggishness<br><input type="checkbox"/> Apathy, lethargy<br><input type="checkbox"/> Hyperactivity<br><input type="checkbox"/> Restlessness<br><input type="checkbox"/> <b>TOTAL</b>  |
| <b>Mouth/Throat</b><br><input type="checkbox"/> Chronic coughing<br><input type="checkbox"/> Gagging, frequent need to clear throat<br><input type="checkbox"/> Sore throat, hoarseness, loss of voice<br><input type="checkbox"/> Swollen or discolored tongue/gums/lips<br><input type="checkbox"/> Canker sores<br><input type="checkbox"/> <b>TOTAL</b> | <b>Mind</b><br><input type="checkbox"/> Poor memory<br><input type="checkbox"/> Confusion, poor comprehension<br><input type="checkbox"/> Poor concentration<br><input type="checkbox"/> Difficulty in making decisions<br><input type="checkbox"/> Stuttering or stammering<br><input type="checkbox"/> Slurred speech<br><input type="checkbox"/> Learning disabilities<br><input type="checkbox"/> <b>TOTAL</b> |
| <b>Skin</b><br><input type="checkbox"/> Acne<br><input type="checkbox"/> Hives, rashes, dry skin<br><input type="checkbox"/> Hair loss<br><input type="checkbox"/> Flushing, hot flashes<br><input type="checkbox"/> Excessive sweating<br><input type="checkbox"/> <b>TOTAL</b>  | <b>Emotions</b><br><input type="checkbox"/> Mood swings<br><input type="checkbox"/> Anxiety, fear, nervousness<br><input type="checkbox"/> Anger, irritability, aggressiveness<br><input type="checkbox"/> Depression<br><input type="checkbox"/> <b>TOTAL</b>   |
| <b>Heart</b><br><input type="checkbox"/> Irregular or skipped heartbeat<br><input type="checkbox"/> Rapid or pounding heartbeat<br><input type="checkbox"/> Chest pain<br><input type="checkbox"/> <b>TOTAL</b>   | <br><b>&lt;10 – Optimal</b> <b>10-50 – Mild Toxicity</b><br><b>50 – 100 Moderate Toxicity</b> <b>&gt;100 – Severe Toxicity</b><br><br><b>GRAND TOTAL: _____</b>  |
| <b>Lungs</b><br><input type="checkbox"/> Chest congestion<br><input type="checkbox"/> Asthma, bronchitis<br><input type="checkbox"/> Shortness of breath<br><input type="checkbox"/> Difficulty breathing<br><input type="checkbox"/> <b>TOTAL</b>  |  |



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### INTERESTS AND GOALS

To allow us to better address your healthcare goals & priorities, please check what applies to you and your interests.

#### What types of care are you open to?

**Chiropractic/Sports Medicine:** This approach involves addressing musculoskeletal and neurological function through addressing postural or biomechanical imbalances. Injury treatment and prevention are often achieved through joint manipulation, active and passive stretching, soft tissue techniques, traction, physical therapy modalities, and therapeutic home exercise programs.

**Therapeutic Massage:** Several forms of deep tissue massage and other forms of body work are offered. Our licensed massage therapists offer targeted treatments for athletes, work and auto injuries, postural stress, and even pregnancy massage.

**Functional Medicine:** Upstream approach to getting to the root cause of many chronic conditions and health concerns including gastrointestinal dysfunction, autoimmune conditions, chronic fatigue, weight gain, mood disorders, cardiovascular health, and skin complaints. Specialty lab testing, supplements, dietary intervention and lifestyle modifications are the most commonly utilized methods with this approach to best address gut function, sensitivities, toxic burdens, hormone and immune function, and inflammation.

**Nutrition:** Professional guidance with meal planning, shopping, and determining the best diet for an individual's specific needs or specific condition. Areas of focus include: weight management, athletic performance, food sensitivities/allergies, Celiac and IBD, cancer, and digestive health.

**Infrared Sauna:** We offer the highest quality Full Spectrum Infrared Sauna therapy with our Sunlighten Sauna. Some of the many benefits include: Detoxification, Weight Loss, Pain Relief, Anti-Aging, Immune Enhancement, Relaxation, Cardiovascular and Skin Health.

**Pulsed Electromagnetic Field (PEMF) Therapy:** Through improving the cell membrane potential via charging the cells of the body, improved circulation, oxygen uptake, mitochondrial function, nutrient uptake, and elimination of cellular waste, this modality proves to be quite an impressive therapy. Recommended for improving athletic performance/recovery, strains/sprains/broken bones, post-surgery, neurological complaints, concussions, and in conjunction with Functional Medicine.

#### Specific Health Goals:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Have More Energy | <input type="checkbox"/> Improve Strength     | <input type="checkbox"/> Improve Concentration |
| <input type="checkbox"/> Sleep Better     | <input type="checkbox"/> Improve Flexibility  | <input type="checkbox"/> Improve Memory        |
| <input type="checkbox"/> Be Free of Pain  | <input type="checkbox"/> Improve Balance      | <input type="checkbox"/> Neurological Support  |
| <input type="checkbox"/> Improve Immunity | <input type="checkbox"/> Reduce Weight        | <input type="checkbox"/> Reduce Depression     |
| <input type="checkbox"/> Heart Health     | <input type="checkbox"/> Sport Specific _____ | <input type="checkbox"/> Reduce Stress         |



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## **INFORMED CONSENT FOR CHIROPRACTIC TREATMENT**

**The Nature of Chiropractic Manipulation:** The doctor will often use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or a “pop”, such as the noise when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, soft tissue therapies, corrective exercises, or active stretching may also be utilized.

**Possible Risks:** As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular incident could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burn, or minor complications.

**Other Treatment Options:** May include over-the-counter analgesics, prescription medications, injections, and surgery.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**No Warranty:** I understand that my doctor at Wellness Doctor, cannot make any promises or guarantees regarding a cure for or improvement of my condition. I understand that my doctor will share with me his/her opinion regarding potential results from chiropractic treatment for my condition and will discuss treatment options with me before I consent to treatment.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Consent To Treat A Minor**

I hereby authorize Wellness Doctor to administer Chiropractic care, as deemed necessary, to my child.

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Parent /Guardian Signature: \_\_\_\_\_



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## Financial Policy

To ensure your treatments are as stress free as possible we have established a clear financial policy.

**Please read and initial next to the policy that applies to you. If you have any questions don't hesitate to ask!**

\_\_\_\_ **Insurance:** We will bill your insurance as a courtesy for you. If you provide us with your current insurance information we will do our best to verify your benefits prior to receiving care, however insurance companies will never allow a quote of coverage to be a guarantee of payment. We will collect 100% of services not covered by your insurance carrier. If you have a copay, co-insurance, or unmet deductible you will be responsible for payment at time of service. **We do offer services that may not be covered by your insurance and you will be responsible for the balance.** Please be aware that some patient's policies are written to where they may have a deductible for certain services and or a copay for certain services. **\*Insurance is a contract between the patient and their carrier, so it is important that you take responsibility for understanding your benefits. \***

\_\_\_\_ **Auto Accident/Personal Injury/Workman's Compensation:** Most Personal Injury and Workman's Compensation claims are covered 100%. However, it is **YOUR** responsibility to provide our office with the documentation necessary to prove a valid claim which includes your claim number, as well as the name(s) of any claims adjustor/attorney, etc. handling the case, their phone and fax number and the mailing address to send bills. Failing to provide the documentation needed will result in immediate conversion of your case to cash, and all payment will be due on receipt. We can send any unpaid claims to your personal health insurance if it was in effect during your treatment as long as you provide us with current insurance information. If you miss more than two appointments and do not call within the 24-hr. cancellation period, appointments with our facility may be terminated.

\_\_\_\_ **Cash: Payment is due at the time of service.** A prompt pay incentive discount is offered for patients that do not have insurance or choose to not use their insurance. Please speak with our front desk staff to go over those prices.

\*Unpaid balances greater than 120 days will be sent to collections and you will be charged an additional 35% to cover the cost of collections (this amount will be added to you bill). \*

**I have read and understand the above Financial Policy.**

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
**Date**



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## HIPAA Acknowledgement of Notice of Privacy Practices

PLEASE REVIEW THE FOLLOWING CAREFULLY AS IT PERTAINS TO THE USAGE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

\*My health information may be created or received by Wellness Doctor, LLC and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

\*We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff, personnel or anyone who is involved in taking care of you and your health.

\*I understand that I have the right to receive and review a written description of how Wellness Doctor, LLC will handle my health information. This written description is known as a NOTICE OF PRIVACY PRACTICES and describes the uses and disclosures of health information made and the information practices followed by employees, staff and other office personnel of Wellness Doctor, LLC and my rights regarding my health information.

\*I understand that the NOTICE OF PRIVACY PRACTICES may be revised periodically. We will not disclose your health information unless we have received written consent. I understand that a copy of summary of the most recent version of Wellness Doctor, LLC's NOTICE OF PRIVACY PRACTICES in effect will be posted in the waiting/reception area.

### Special Permission Request:

I give my permission for Wellness Doctor, LLC to leave messages regarding appointments on my home/cell phone answering machine.

Initial: \_\_\_\_\_ Date: \_\_\_\_\_

I give my permission to speak with/leave messages regarding treatment, billing and regarding appointment status left with my spouse, partner, caregiver.

Initial: \_\_\_\_\_ Date: \_\_\_\_\_ Name: \_\_\_\_\_

By signing this agreement, I attest that I understand the information above. Our posted Privacy Health Information provides more detailed information about the usage and disclosure of your (PHI). You have the right to review and/or request a copy of this policy before signing this consent. This release will revoke by written permission only.

I understand that I must send a written request to Wellness Doctor, LLC to revoke this release.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_





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## MASSAGE PATIENT WAIVER FORM

**Please read and initial the following information if you think you would like/need massage at our clinic.**

---

\_\_\_ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular and fascial tension, improvement of circulation and energy flow.

\_\_\_ If I experience pain or discomfort during the session, I will immediately inform the Licensed Massage Therapist (LMT) so that pressure/strokes can be adjusted to my level of comfort. I will not hold Wellness Doctor or the LMT responsible for any pain or discomfort I experience during or after the session.

\_\_\_ I understand that the services offered today are not a substitute for medical care. I understand that the LMT, is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

\_\_\_ I affirm that I have notified the LMT of all known medical conditions, medications, and injuries.

\_\_\_ I agree to inform the LMT of any changes in my health and medical condition (ex. pregnancy). I understand that there shall be no liability on the LMT should I forget to do so.

\_\_\_ By signing this release, I hereby waive and release Wellness Doctor and the LMT from all liability, past, present, and future relating to massage therapy and bodywork.

---

Patient Signature

---

Date



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