NEW PATIENT INFORMATION

Name____Date of Birth_____/_____/_____ Age__________

Address____Home Phone_____________________________

City______________________State______________Zip____________Cell Phone______________________________

Birth City____Birth State_____________________________

Email Address____ Work Phone____________________________

Gender M / F Marital Status S M D W #of Children__________ Occupation______________________________

Emergency Contact____ Phone__________________________________

Referred by____

Confirmation of New Patient Appointment: **I understand the clinic reserves the right to charge me and my credit on file, the full-service rate for all missed appointment(S) or those appointment(S) cancelled less than the required 48 hours in advance.**

CREDIT CARD INFORMATION: Card Type V / MC / D / Amex Name on Card__________________________________

Card Number____ Expiration_________________Security Code________

Health History: Please describe your five (5) most prevalent symptoms:__________________________________

____

____

List any surgeries and/or hospitalizations____

Describe the following

Sleep____

Energy____

Diet____

Digest____

Elimination____

Pain____

Emotional Well being____

Medications	Supplements
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

List any Allergies____

ACKNOWLEDGEMENT & WAIVER OF LIABILITY

I accept full responsibility for my health and voluntarily complete this *Acknowledgement & Waiver of Liability.*

I acknowledge I am seeking the consultation and treatment services of Susan B. Rohr, BSN, RN, for alternative healing suggestions and therapies, which I fully understand are not medical diagnosis or treatment or substitutes for medical diagnosis or treatments.

I certify that with respect to any medical conditions or concerns I have been advised to consult with my personal health care physician. Understand Susan B. Rohr is not a primary care physician and I do not view her as my physician. Her practice specializes in a natural approach to healing including, but not limited to, nutrition and energy therapies.

I understand I am seeking analysis and/or therapies that may not be FDA registered or approved and may not be offered by practicing physicians (allopathic or otherwise) and which may be considered experimental. These include, but are not limited to: Ondamed, Qi5 Body Scan & Balance System, Photon Genius, MCN Iasis Neurofeedback, Aura PTL II Laser Therapy Clinical Program, Ionic Footbath, FLOWpresso, HOCATT, Alpha-Stim, Whole Body Tuner and additional Rejuvenation and Detoxification and Energy Balancing techniques.

I understand and agree neither Susan B. Rohr, and any staff of Susan B, Rohr, or the staff at Brookfield Health & Wellness, LLC, make any claim whatsoever, express or implied, regarding effects or outcomes of the analysis or therapies provided, and shall not be liable for same.

My signature below indicates I have carefully read and reviewed this *Acknowledgement and Waiver of Liability* statement and I fully understand all its terms and conditions. I recognize and accept all risks and limitations involved in seeking advice and treatment therapies Susan B Rohr, Brookfield Health & Wellness, LLC, and all associates, employees, agents, and representatives thereof. Accordingly, I have not relied upon any promises, agreements, or representation by Susan B. Rohr, VSN, RN and Brookfield Health & Wellness, LLC, or any associates, employees, agents, or representative thereof, concerning the treatment provided.

UNDERSTOOD, ACCEPTED AND AGREED

______________________________________ ______________________________________

Patient Signature Date

____

Patient Printed Name

If minor, Parent/Legal Guardian Signature____

NOTICE OF PRIVACY PRACTICES

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal health care information is protected for privacy. The Privacy Rule was also created to provide a standard for certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient or carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect he privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information and information about treatment, payment of health care operations, to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

UNDERSTOOD, ACCEPTED AND AGREED

____ ____

Patient Signature Date

____

Patient Printed Name

If minor, Parent/Legal Guardian Signature____

CANCELLATION POLICY

At Brookfield Health & Wellness, LLC, we understand unanticipated events occur in everyone's life. Unforeseen events such as flight delays, car problems, traffic considerations, business meetings and project deadlines, are a few reasons why one might consider cancelling a treatment. In our effort to provide a unique and tailored treatment to each of our patients, and out of consideration of our practitioner's time, we have adopted the following cancellation policy:

CANCELLATION POLICY

A credit card will be required to guarantee and reserve your *Ondamed* appointment time. Your credit card will not be charged unless you choose to use it as payment for treatments at the completion of your appointment. If, for some reason, it is necessary to cancel your *Ondamed* appointment please note a 48-hour notice is required to prevent your account from being charged.

For all other treatments, excluding an *Ondamed* appointment, a 24-houor notice is required to cancel your appointment(s). The total amount of the treatments scheduled will be charged in full for patients who "no-show" or fail to cancel his/her appointment(s) within the required 24-hour notice.

If you are booking your appointment(s) within 24 hours of the actual appointment, there is no cancellation, and you will be charged the full amount of the appointment if you fail to arrive.

LATE ARRIVAL POLICY

As a courtesy to all patients and staff, appointments will be automatically cancelled if you arrive 15 minutes past your scheduled start time and will be charged according to our cancellation policy. We regret that late arrivals will not receive extension of scheduled appointments. In special cases, and when our schedule allows, we may be able to accommodate a partial or full appointment. This will be at our discretion and only with proper, advanced notification of your late arrival.

I understand the clinic reserves the right to charge my credit card on file the full-service rate for all missed appointments or those cancelled not in compliance with the Brookfield Health & Wellness, LLC, *Cancellation Policy.*

***It is understood all packages purchased must be used with 90 days of purchase and are non-refundable and non-transferrable.*

UNDERSTOOD, ACCEPTED AND AGREED

________________________________ ________________________________

Patient Signature Date

____

Patient Printed Name

If minor, Parent/Legal Guardian Signature____

RELEASE OF INFORMATION

Patient Name___________________________________

The above patient gives permission for the individual(s) listed below to obtain information related to his/her appointment information, treatment(s), and/or health record at Brookfield Health & Wellness, LLC and Kienol Chiropractic:

Name___________________________________ Relationship_________________________

Home___________________________________ Cell_________________________________

Email____

Name___________________________________ Relationship_________________________

Home___________________________________ Cell_________________________________

Email____

Name___________________________________ Relationship_________________________

Home___________________________________ Cell_________________________________

Email____

___________________________________ ___________________________________

Patient's Printed Name Date

____

Patient Signature

If minor, Parent/Legal Guardian Signature____

PHOTO / VIDEO RELEASE

I hereby grant Brookfield Health & Wellness, LLC, the irrevocable right and permission to use photographs and/or video recordings of me on websites and in publications, promotional flyers, educational materials, or for any other similar purpose without compensation to me.

I understand and agree that such photographs and/or video recordings of me may be placed on the internet. I also understand and agree that I may be identified by name and/or title in printed, internet or broadcast information that might accompany the photographs and/or video recordings of me. I waive the right to approve the final product. I agree that all such portraits, pictures, photographs, video and audio recordings, and any reproductions thereof, and all plates, negatives recording tape and digital files are and shall remain the property of Brookfield Health & Wellness, LLC.

I hereby release, acquit and forever discharge Brookfield Health & Wellness, LLC, agents' officers and employees of the above-named entity from any and all claims, demands, rights, promises, damages and liabilities arising out of or in connection with the use or distribution of said photographs and/or video recordings, including but not limited to any claims for invasion of privacy, appropriation of likeness or defamation.

I hereby warrant that I am eighteen (18) years old or more and competent to contract in my own name, or if I am less than eighteen years old that my parent or guardian has signed this release form below. This release is binding on me and personal representatives.

____ _________________________

Signature of Individual Photographed/Video Recorded Date

____ _________________________

Signature of Witness Date

If individual photographed/video recorded is under eighteen (18) years old, the following section must be completed:
I have read and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am eighteen (18) years old or more and that I am the parent or guardian of the child named above.

____ ____________________

Signature of Parent/Guardian of Individual Photographed/Video Recorded Date

Printed Name of Parent/Guardian ____

____ _________________________

Signature of Witness Date