Brookfield Health and Wellness, LLC
Integrative healing for the body, mind, and spirit

NEW PATIENT INFORMATION

Name: _____ Date of Birth: ___/___/___ Age: _____

Address: _____ Home Phone: _____
Street

_____ Cell Phone: _____
City State Zip

Email Address: _____ Work Phone: _____

Gender: M / F Marital Status: S M D W # of children____ Occupation: _____

Reason for Visit _____

_____

Referred By_____

Emergency Contact: _____Phone: _____

I understand the clinic reserves the right to charge me and my credit card on file, the full-service rate for all missed appointments or those appointments cancelled less than 48 hours in advance.

CREDIT CARD INFORMATION: Card Type_____Name on Card:_____
Card Number:_____Expiration:_____ Security code:_____

Medications:	**Supplements**:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List any surgeries or hospitalizations: _____

Please list any allergies: _____

_____

Please Describe Your Five Most Prevalent Symptom(s):_____

_____

_____

_____

Describe the Following:

Sleep:_____

_____

Energy:_____

_____

Elimination:_____

_____

Digestion:_____

_____

Diet:_____

_____

_____

Pain:_____

_____

_____

Emotional Wellbeing: _____

_____

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ACKNOWLEDGMENT & WAIVER OF LIABILITY

I accept full responsibility for my health and voluntarily complete this Acknowledgment & 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 treatments or substitutes for medical diagnosis or treatments.

I certify that with respect to any medical conditions or concerns I may have, I have been advised to consult with my personal health care physician. I 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: Photon Genius, Rejuvenation and Detoxification, and Energy Balancing techniques.

I understand and agree that 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 Acknowledgment and Waiver of Liability statement and I fully understand all of 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 representations by Susan B. Rohr, BSN, RN and Brookfield Health & Wellness, LLC or any associates, employees, agents, or representatives thereof, concerning the treatment provided.

***Packages purchased must be used within 90 days of purchase and are Non-refundable & Non-Transferable.*

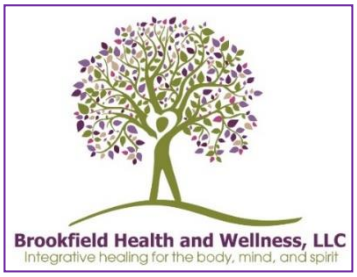
UNDERSTOOD, ACCEPTED AND AGREED

_____ _____

Patient Signature Date

_____

Patient's Printed Name



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 in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the 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 or health care operations, in order 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

_____ _____

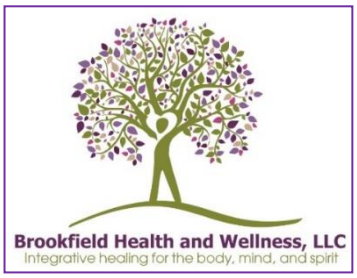
Patient Signature Date

_____

Patient's Printed Name

I give permission to the following people to receive and/or discuss my medical information with the providers at Brookfield Health & Wellness, LLC:

_____



CANCELLATION POLICY

At Brookfield Health and Wellness, 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 clients and out of consideration of our clinician'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 card will not be charged; however, you may use it to pay 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 in order to prevent your account from being charged.

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

If you are booking your appointment 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 our other patients and staff, appointments will be automatically cancelled 15 minutes after scheduled start time and charged according to cancellation policy. We regret that late arrivals will not receive extension of scheduled appointments. In special cases, and when our schedule will allow, 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 Brookfield Health & Wellness, LLC, Cancellation Policy.

UNDERSTOOD, ACCEPTED AND AGREED

_____ _____

Patient Signature Date

_____

Patient's Printed Name