BLU Synergy
WHOLISTICS
k.osher n.atural o.rganic w.hole

New Client Profile

Welcome! Please complete this profile as well as the companion Health History.

*First Name*_____ *Middle* Initial _____ Last *Name*_____

Address:_____

City _____ *State* _____ *Zip*_____ *Birth Date*: _____

Primary Phone:_____ *Cell Phone*: _____

E-mail: _____

Would You Like To Be Included In Our Emails For Savings On Services & Products? We promise to never sale, share, or misuse your email address. You can unsubscribe whenever you choose.
Click Here to Accept: ☐

How Did You Hear About Us?
☐ Family Member or Friend ☐ Email Campaign ☐ Facebook ☐ Internet Search
Other: _____

Dear Valued Customer,

Thank you very much for choosing us for your health care needs. We know you have many choices and are excited to have the opportunity to serve you. If you ever have any questions, concerns, or ideas for ways that we can better serve you please let us know. We promise to work to exceed your expectations and help you discover what life feels like at your very best.

Much Love,

A. E. Manning
Certified Holistic Nutritionist
blusynergywholistics@gmail.com

Email Me and Tell Me about Your Experience

Front Desk Staff Only **Entered By:** _____

Booker: ☐ **Email:** ☐ **Facebook:** ☐ **Referral Card:** ☐

New Client Financial Policy Disclosure & Consent

Dear Valued Client,

In an effort to ensure prompt payment to our therapists and staff for their time and service we require that each Client have a valid Credit Card on file. Each Client reserves the right to select their method of payment, be it credit card on file, additional credit card, check or cash after services are performed. We reserve the right to charge the card on file for the full balance due under the following scenarios:

1. The Client's verbal or written authorization.
2. Checking Non-sufficient Funds. An additional $25 will be added to the balance due to cover banking costs.
    a. Client will be notified via telephone or email of NSF and be granted 24 hours to rectify the payment arrangements. If the payment has not been rectified within 24 hours then we will attempt to charge your credit card on file for the balance due plus $25.
3. Past Due balance exceeding 15 Days without written payment arrangements being agreed upon.
    a. A Late Fee equaling $25 will be added to each past due after the first 15 day grace period and then again every 30 days until the account has been paid in full or payment arrangements have been made to our satisfaction.
    b. All past due accounts exceeding 45 days and without payment arrangements are subject to collection through our 3rd party debt collector and reporting to the three credit bureaus.

Any Client whose account becomes past due and whom fails to make the necessary payment arrangements will be asked to make all payments for services rendered and products received in full via valid credit card same day of services rendered and products received from that point forward.

The Address MUST Match the Billing Address for your Credit Card.

Visa or Master Card Number: To Be Provided At Time of Initial Scheduling – All Information is Encrypted

Expiration Date: Encrypted CVV2 Code: Encrypted – Not Retained

Zip Code: Encrypted

Thank You for Choosing Us. ☺

I have read and agree to the terms for payment and authorize the use of my credit card on file per the terms of this agreement.

Print Name	Signature	Date

Our Cancellation Policy is as follows: All appointments cancelled or rescheduled with less than 48 hours remaining prior to treatment are subject to a non-refundable $50.00 fee at our discretion. This fee is transferable to the next immediate appointment one time only. If the next appointment or any subsequent appointment is also cancelled within this 48 hour window prior to treatment, then the $50.00 fee is defaulted in favor of our offices and an additional $50.00 fee will be charged each time a session is vacated with less than 48 hour notice from that point forward for said client. We do this to protect the schedules of each of our therapists as well as to ensure therapy availability for each of our clients. In the event of any dispute we promise to make every accommodation to resolve these matters in a way that is favorable to our clients and our employees.

Our No Show Policy is as follows: All appointment no shows will be charged the full session. Again, we will make every effort to resolve any disputes in a fair matter to all parties. These policies are placed into effect with the intention of protecting our clients, our employees and the work place that facilitate our healing practices.

Children of Divorced Parents Policy is as follows: When a child of divorced parents is seen in our offices or a parent consults with one of our clinicians via telephone, payment will be expected from whichever parent schedules the child's visit and accompanies the child to the visit. At no time will we bill ex-spouses or parents who are not present during the medical visit without their direct consent, unless they have previously authorized payment with our offices in writing or verbally over the phone. If one parent has full custody (or there is another appointed guardian), please be aware that we will require authorization from said parent/guardian to treat and/or discuss the child's case with the parent (family) who does not have custody rights during that time. Thank you for understanding our legal duty.

Non-liability Accident/Worker's Comp Insurance Claims Policy is as follows: We do defer payments for non-liability accident related insurance claims if the client can provide proof of insurance claim number and we can verify this information. Clients who elect to utilize this option will be charged in full for their initial office visit and $75 for each office visit thereafter. Clients will also be required to pay for supplementation in full unless their insurance company authorizes full payment of the cost of their supplement program as well. At the time of settlement all outstanding balances are immediately due.

Health Insurance Policy is as follows: We do not accept insurance at this time. As a result, payment in full is expected at time of service. If you would like to submit paperwork to your insurance company for reimbursement, please ask and you will be provided you with the appropriate *Superbill or Reimbursement Form* to do so. The cost of this service is $20 per request. Please allow up to 1 week for our office to prepare the necessary paperwork for submission. **Historically, Medicare/Medicade and Tricare/Triwest will not reimburse for office visits or lab work.**

Client Decorum Policy is as follows: We reserve the right to terminate treatment for any violation of appropriate client decorum. This may include, but is not limited to: Violent, Aggressive, or Threatening behavior towards a member of our healing team or another client, repeated dishonesty, lying, or misleading information being presented as truth, failure to regularly follow the directions and recommendations of our healing team, repeated late cancellation or no shows, failure to pay balance in full in a timely fashion, inappropriate sexual misconduct, spousal abuse, child abuse, arriving to our clinic intoxicated, or inappropriately soliciting team members or staff.

Financial Hardship Policy is as follows: We will make every effort to ensure continuity of care by creating payment arrangements for every established client who encounters financial hardship, particularly in the case of parents with children. We are here to help where we can.

I have read, understand, and agree to abide by each of the additional administrative policies detailed in this agreement.

Print Name	Signature	Date

Informed Consent

I _____ hereby consent to and authorize clinicians to provide professional healthcare services on my behalf and/or the behalf of my children.

I further understand that the healing therapies I am endeavoring into are based upon energy movement, detoxification, nutritional optimization and physical manipulation of the soft tissues of the body designed to alleviate pain and fatigue syndromes that accompany potential pathology. As with many energy based therapies, the 100% natural therapies utilized by this healing center have the ability to produce profound changes in the musculoskeletal frame, nervous system, and especially within the immune, lymphatic, cardiovascular, respiratory, urinary, reproductive, and digestive systems.

As a result it is not uncommon for a person new to this style of natural healing to experience unfamiliar sensations during and following treatments. Among these sensations **clients have reported very natural sensations of tingling, body twitching, lightness, yawning, movement in areas of the body not being directly treated, cold hands and feet, sweating, as well as uncontrollable emotional expressions particularly in cases of previous emotional or physical trauma**. These sensations are very natural and an important part of the healing process, still we invite you to stay in close communication with your clinician and support therapists if any doubt or curiosity exists regarding your treatments.

Our treatments are intended to improve your energy, alleviate pain, and restore your body, psyche, and spirit for long-term healing resolutions. Your healing team is happy to work directly with other physicians and therapists that you currently work with so long as their treatments do not interfere with our treatments and are in your best interest. We are here to help you in the most sincere meaning of the word.

Following your treatment you may experience the following Healing Responses:

1. Temporary Acute Muscle and Soft Tissue Tenderness.
2. Temporary Diminished Control Over Your Emotional State.
3. Temporary Fatigue, Desire sleep for an extended period of time.
4. Etc.

A Healing Response tells us that the therapies being utilized have produced changes that your body is now integrating as your health improves toward our mutual goals. If you ever have any questions or concerns feel free to contact us directly via email or telephone and we will get back to you promptly if we are unavailable.

As this is a voluntary endeavor, we remind you that you have the right to discontinue treatments at your discretion and would advise you to discontinue any treatments that you are uncertain of until such time as you can speak with your clinician and confirm the safety of continuation.

Informed Consent Continued

As a new Client, I agree to:

1. Fully disclose all physical and/or psychological health conditions that may be necessary for my clinician and support therapists to know in order to assure my safety, honor my emotional history, and allow my healing team to provide me with the best possible healing experience.
2. Inform my clinician immediately, via phone or email, of any physical or emotional discomfort or pain too intense to manage or that lasts for more than 2 days (48 hours) following a treatment.

I hereby authorize the clinicians and support staff to perform the following specific procedures as necessary to facilitate my assessment and design recommended treatments:

Holistic use of nutrition: Therapeutic nutrition and nutritional supplementation.
Botanical medicine: Botanical substances may be prescribed as teas, alcohol or glycerite based tinctures, capsules, tablets, creams, plasters, or suppositories.
Lifestyle counseling and hygiene: Diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction, and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, aggravation of pre-existing symptoms, discomfort, pain, infection, burns, nausea, light headedness, inconvenience of lifestyle changes. **Please notify an office representative if you experience any symptoms which may be secondary to the above procedures or if ever in doubt.**

Potential benefits: restoration of energy, health and the body's maximal functional capacity without the use of pharmaceuticals or surgery, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female clients must alert the clinician if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by this office or my clinician, therapeutic staff, or representatives regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Informed Consent Continued

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself, my legal representative, or unless it is required by law. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes, and that my identity will be protected and kept confidential. I understand that any questions I have will be answered by my clinician to the best of his/her ability.

I have read, understand, and consent to the terms of treatment and that I am responsible for my health.

Print Name	Signature	Date

Effective As Standard Office Policy Concerning Informed Consent as of September 1, 2015

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In compliance with the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), We have established privacy policies and procedures relating to the protected health information of her clients. Protected health information is information related to your past, present, or future physical or mental health or condition, or payment for such, in which you personally could be identified. HIPAA requires that providers must maintain the privacy of protected health information, provide a notice of their legal duties and privacy practices, and abide by the terms of the privacy notice currently in effect.

If you have any questions about our privacy practices or any of the information contained in this Notice of Privacy Practices for Protected Health Information ("Notice"), you should contact a representative of this office.

A written copy of this Notice will be provided to any person requesting it, whether or not they are a current client. All clients will be given a copy of this Notice at the time of the first service provided to them following the effective date listed above. This Notice will be posted prominently and copies will be made available in our office.

We reserve the right to make changes to the Notice and have any new provisions become effective for all protected health information. If any material changes are made to the uses or disclosures of protected health information, the individual's rights, our legal duties, or other privacy practices stated in this Notice, this Notice will be revised. The revised Notice will be posted prominently in our office, and we will make the revised Notice available to anyone who requests a copy.

Your Rights as a Client with respect to your protected health information, you (or your personal representative, with legal authorization) have certain rights:

1. To obtain a paper copy of this Notice of Privacy Practices for Protected Health Information upon request.
2. To revoke your consents or authorizations.
3. To inspect and obtain a copy of the health information that is used to make individual healthcare decisions about you (so called "designated record sets").
4. To appeal decisions we make regarding denial of access to your records.
5. To request amendments to your health record.
6. To dispute decisions we make regarding denial of amendments to your records.
7. To request restrictions on certain uses and disclosures.
8. To request that confidential communications take place by alternative means or to alternative locations.
9. To obtain an accounting of disclosure.
10. To lodge a complaint with us or with the appropriate local licensing board if you believe there has been a HIPAA privacy violation, without fear of retaliation, coercion, or intimidation. However, we would greatly appreciate the first opportunity to resolve any problems before a complaint would need to be filed.