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PATIENT INFORMATION

Today's Date: _____

Name: _____

Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Emergency contact: _____ Relationship to patient: _____

Primary Physician Name: _____ Contact Number: _____

HEALTH INFORMATION

Please list your health concerns in order of priority:

1._____

_____

_____

Rate Pain or Discomfort:

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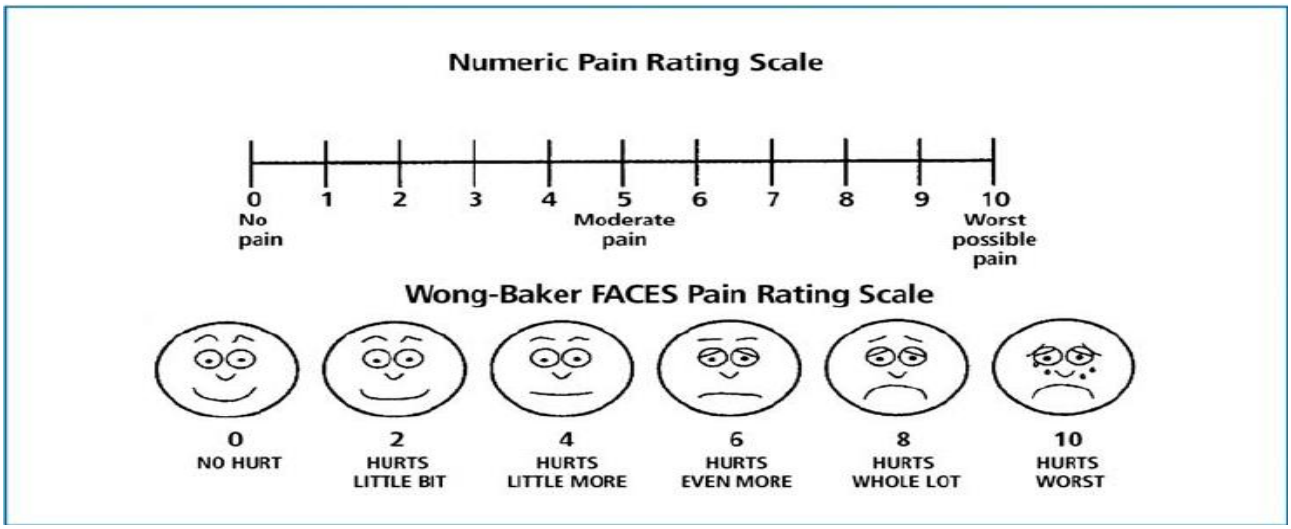
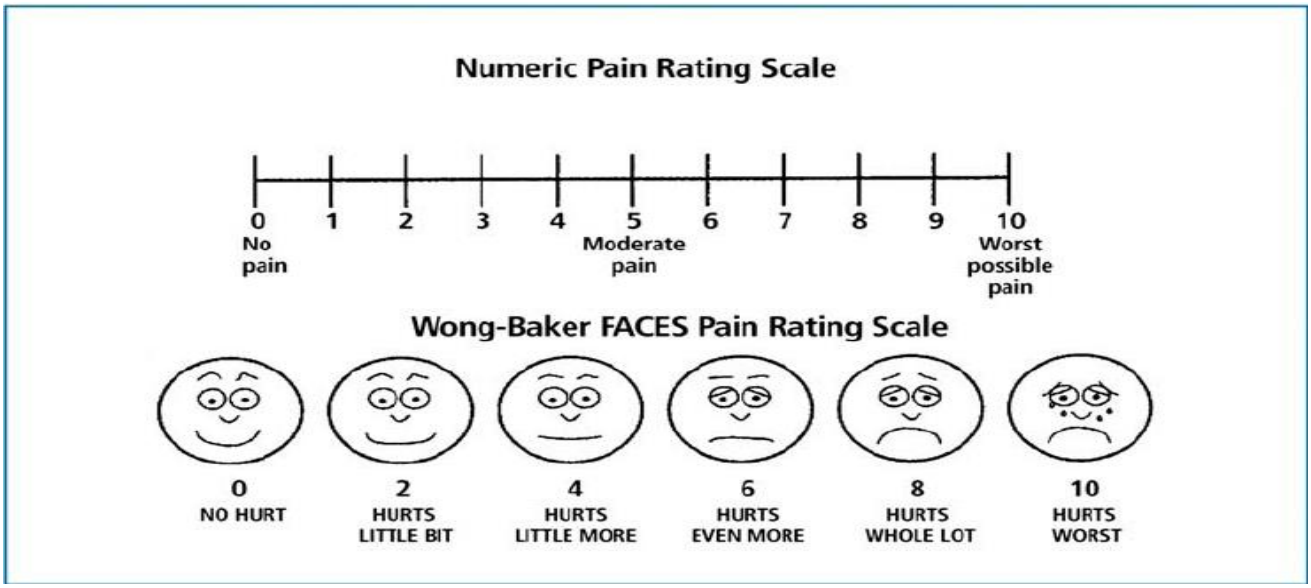


2._____

_____

_____

Rate Pain or Discomfort:



Other concerns:

_____

_____

_____

How long have you had this problem?

1. _____

2. _____

Other:_____

Have you received a medical diagnosis? ____ Y ____ N

If yes, please list:

_____

_____

Medications/Supplements taken in the last 3 months:

Medication	Dosage	Reason	Date Started

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Supplement	Dosage	Reason	Date Started

Everything I have written and answered in this form is true to the best of my knowledge. I will update this office when there are significant changes.

Signature: _____

Date: _____

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HIPAA Consent Agreement Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, **Wild Roots Health**, originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **Notice of Information Practices,** if requested, that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Wild Roots Health is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Wild Roots Health has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

Signature of Patient or Legal Representative Witness

Copy of HIPAA policies requested: (initial) _____

Email for a copy of HIPAA to be sent: _____

Signature_____ Date: _____

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ACUPUNCTURE INFORMED CONSENT

PRINTED NAME:_____

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me.

I understand that methods of treatment may include, but are not limited to, acupuncture, Chinese herbal medicine, and nutritional counseling. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses.

I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment, which the clinical staff thinks at the time, based upon the facts then known, is in my best interest.

I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Or Patient Representative)

PATIENT SIGNATURE: _____Date_____

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YOGA WAIVER FORM

***Please note, all of the information on this form is kept confidential.*

Name: _____

Address: _____

City: _____ Zip Code:_____

Email: _____

EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE NUMBER: _____

Have you practiced yoga before? YES/NO (Please circle)

If YES, for how long? _____

Limitations/Injuries: _____

Do you have numbness/pain in (circle all that apply): neck shoulders elbows hands wrists hips

lower back upper back knees feet other (please note): _____

WAIVER

If at any time during the class, you feel discomfort or strain, gently come out of the posture. You may rest at any time during the class. It is important in yoga that you listen to your body, and respect its limits on any given day.

I, the undersigned, understand that yoga is not a substitute for medical attention, examination, diagnosis, or treatment. I should consult a physician prior to beginning any activity program, including yoga.

I recognize that it is my responsibility to notify my teacher of any serious illness or injury before every yoga class.

I will not perform any postures to the extent of strain or pain.

I accept that neither the instructor, nor the hosting facility, is liable for any injury, or damages, to person or property, resulting from the taking of the class.

Those under 18 years of age must have this form signed by a parent or guardian.

_____ _____ _____

Name (Print) Signature Date

_____ _____ _____

Parent/Guardian Signature Date

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PEMF INFORMED CONSENT FORM

Name:_____

Address:_____

City: _____State:_____ ZIP_____

Email: _____Phone:_____

Magnetic therapies can alter circulation, stimulate cell and tissue repair, stimulate nerve cells, cause relaxation, affect blood pressure and heart rate, alter the absorption of medications and nutrients, affect acupuncture energy movement, stimulate vision changes, among many other actions. So, overreactions by the body, perceived or measurable, do happen.

Sudden increases in circulation, especially in ischemic tissues (areas with restricted or reduced blood flow) may lead to uncomfortable increases in circulation for a short time after the magnetic field has been applied. These sudden improvements in circulation may also lead to aggravations of existing extensive or severe inflammatory processes, typically in the skin. Aggravation of hives is likewise possible and should be considered before starting treatment.

When nerve cells are suddenly stimulated, pain may be temporarily aggravated due to the increased signal traffic in the nerve and/or improved circulation to the nerve/s.

Magnetic therapies commonly lower blood pressure and decrease heart rate, actions that are almost always positive. These actions can pose a concern for individuals who are elderly, on medication with blood-pressure-lowering actions, are frail, have labile or easily altered blood pressures, have been on extensive bed rest, are in shock or have overwhelming systemic infection, or who have non-brisk, compensatory vascular reflexes. Please let your provider know if you are concerned with this, as they will want to allow adequate time for you to get up from treatment to avoid fainting or light-headedness. Usually, these reactions settle down as magnetic therapy continues and stabilizes body functions.

Possible reactions include: increased fatigue, aggravations of sleep, increased pain, vague weakness or loss of energy, metallic tastes, dizziness, “brain fog”, thirst, increased urination, warmth, cold sensations, prickly sensations in the skin, colors in the visual fields, heaviness of the extremities and palpitations.

If the adverse reactions are intolerable, we can lessen them by making some small changes to your protocols, include lowering intensity, decreasing treatment times, and limiting the amount of the body that is being treated. Reactions tend to diminish relatively quickly with continued treatment.

You are encouraged to discuss your concerns with your provider and discontinue treatments if you wish.

PEMF therapy is not recommended if:

- You have any metal implants or implanted electronic devices including pacemaker, defibrillator, cochlear hearing device, etc.
- You are pregnant.
- You are actively bleeding.

If you experience any natural reactions such as nausea, headache, fatigue or any uncomfortable sensations, let your PEMF practitioner know right away.

- ❑ I hereby state that I am at least 18 years of age.
- ❑ I have read the above information in its entirety and hereby request Wild Roots Awakening to provide Pulsed Electromagnetic Field Therapy (PEMF Therapy).
- ❑ I hereby release Wild Roots Awakening against any and all liability or claims arising out of, or related to, my use of the PEMF Therapy.

NAME: _____ Date: _____

SIGNATURE: _____

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Refund Policy

It is *Wild Roots Awakening* mission to provide quality service and care to each patient. We strive to educate and treat patients individually. We also understand that as unique individuals, patients may not progress at the rate they desire despite our best efforts. *Wild Roots Awakening* therefore offers a refund on any unused prior-paid services.

Unused packages or services will be calculated based on total paid cost and remaining balances will be refunded. No used service costs will be refunded.

Products such as herbal supplements, nutritional supplements, CBD creams and other can be returned with a full refund if unopened. Opened products will not be refundable.

Signing this the patient acknowledges and agrees to *Wild Roots Awakening* refund policy:

Signature:_____

Date: _____

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Office Use Only

MC:

PTs:

T:

P:

OM Diagnosis:

Rec:

Other: