New Client Information

First Name: _____ Last Name:_____

DOB:_____ Name of Parent/Legal Guardian if applicable:_____

Address: _____

Telephone: _____Email:_____

Age:_____ Occupation:_____

Who to reach in case of an emergency:_____ Phone #: _____

How did you hear about Allergy Center of Bend? _____

Referred by? _____

Are you currently receiving healthcare? _____ If yes, name of physician: _____

Condition being treated: _____

What are your most important health concerns?

1

2

3

Please list tested or suspected allergies and related symptoms:

_____

Please list any prescription medications or over-the-counter supplements you are taking:

_____

Do you have a current medical condition(s) (e.g. Epilepsy, Pregnant)?

_____

Surgeries: _____

Do you smoke? _____

Signature_____ **Date**_____
(If under the age of 16, must be signed by Parent or Legal Guardian)

New Client Information

Client Name_____ **Date**_____

In order to receive the best possible results, it is important to read and understand the following information:

- Some cases may require treating preliminary items that are contained within a substance such as vitamins, minerals, phenolics and/or sugars. For example, sugar may need to be addressed before proceeding with alcohol, grains or fruit. After addressing preliminary items, patients may choose what order remaining substances are treated.

- It is possible to treat numerous items in one treatment if they are in the same family. For example, dairy products (milk, cheese and yogurt) and calcium may be treated at one time. However, dairy and wheat, or tomatoes and pollens may not be cleared at the same time. It is also possible that an item must be treated in more than one session, which can only be determined during the treatment.

- We cannot guarantee how many sessions each substance will require to reduce the symptoms associated with that item.

- When addressing a condition, instead of a single substance or family of substances, multiple items may be contributing to the symptoms. Therefore, such conditions may require multiple sessions to relieve the symptoms associated with that condition.

Please adhere to the following guidelines:

- Do not smoke or wear strong perfume or essential oils 2 hours prior to coming to the clinic.
- Do not eat food or chew gum during the treatment.

Office Policies:

- Our office has a 48-hour cancellation policy. Late cancellations or no-shows will be charged for the session.
- Please arrive 10 minutes prior to your appointment time.

The following is for the practitioner to complete:

	Amines		Glutamates		Alcohol		Cat
	Beans		Grains		Artificial Sweetener		Dog
	Caffeine/Coffee		Meat		Fruit		Dust
	Calcium		Protein		Fish/Shellfish		Dust Mites
	Chicken		Salicylates		Herbs/Spices		Flowers
	Chocolate		Salts		Nuts		Fungus
	Corn		Soy		Potato		Grass
	Cow Dairy		Sugar				Mildew/Mold
	Eggs		Turkey		Sulfites		Phenolics
	Flavor Enhancers		Vitamins		Tannins		Plants
	Food Coloring		Minerals				Pollens
	Food Flavorings				Enzymes		Trees
	Food Phenolics				Acids		Weeds
	Preservatives						

Waiver and Release

I, _____, (the "Undersigned"), hereby consent to receive treatment at the Allergy Center of Bend, LLC, located in Bend, Oregon.

Allergy Center of Bend, LLC, requires 48 hours notice for any canceled appointments. No shows or appointments canceled within 48 hours of scheduled time will be charged the full price of your session. To cancel or reschedule, please call us at 541-241-8782. We do not give refunds.

In scheduling this appointment, you hereby release Allergy Center of Bend, LLC, Kristen Jividen, their agents, employees, successors and assigns, and their respective heirs, personal representative, affiliates, and any or all persons, liable or who might be claimed to be liable, whether or not here in named, none of whom admit any liability to the undersigned, but all expressly denying liability, for any, and all actions, causes of action, claims and demands of any and every kind and also any and all injuries and damages that may occur in the present or develop in the future.

I understand that there is no implied or stated guarantee of success or effectiveness of individual technique or series of appointments. I hereby acknowledge that this is not a substitute for medical care, examination or diagnosis. The Allergy Center of Bend, LLC and all of its employees assume no responsibility for medical conditions requiring the attention of a medical doctor, or necessary adjustments to prescribed medications during or after the completion of treatments. We do not diagnose, give medical advice, make claim to cure, or predict the future. We reserve the right to refuse service to anyone.

I understand that the clinic does not treat cases of anaphylaxis and I agree to fully disclose all information regarding any life-threatening allergies or allergies resulting in anaphylaxis.

☐ **No, I do not have any life-threatening allergies**

☐ Yes, I have the following allergies that may cause anaphylaxis:

_____

Governing Law/Venue: This agreement shall be governed and construed in accordance with the laws of the State of Oregon. Any claim, action, or suit between Allergy Center of Bend, LLC and Client that arises out of or relates to performance of this agreement shall be brought and conducted solely and exclusively within the Circuit Court for Deschutes County, Oregon. Provided, however, that if any such claim, action or suit may be brought only in a federal forum, it shall be brought and conducted solely and exclusively within the United States District Court of Oregon. Client, by execution of this agreement, hereby consents to the in personal jurisdiction of said courts.

I agree that neither I, my heirs, assigns or legal representatives will sue or make any other claims of any kind whatsoever against Allergy Center of Bend, LLC, or its members for any personal injury, property damage/loss, or wrongful death, whether caused by negligence or otherwise.

I have read and agree to the terms above.

IN WITNESS THEREOF, the undersigned executed the Agreement as of

_____ _____

Signature of Undersigned Date

_____ _____

Signature of Parent or Legal Guardian Signature of Practitioner

Information Release Form
(HIPAA Release Form)

Name:_____Date of Birth: _____

Release Information

[ ] I authorize the release of information including the diagnosis, records;
examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*):_____between (*time*):_____

Signed:_____Date:_____/____/_____

Witness:_____Date:____/____/_____