



New Patient Information

NAME: _____ Today's Date _____

DOB _____ Age _____

Address _____

Preferred Phone _____ Occupation _____

Email _____

Emergency Contact: Name _____ Phone _____

Referred by _____

What is the primary reason for seeking care at our office? _____

Please list any surgeries (with dates): _____

Please list any medications that you are currently taking: _____

Fee Policy: It is our policy that you pay the entire session fee at the time of each session. We will provide you with a receipt for you to send to your insurance company. We will provide a minimum of one month's notice of any changes to our fees.

Cancellation Policy: If you need to change or cancel your appointment please do so with a minimum of 24 hours notice. Failure to do so will result in being charged \$75 for a late cancel or a no show. (less than 24 hours)

I understand the fee and cancellation policies.

Signature: _____ Date: ____/____/____

LifeThyme Wellness Informed Consent

NAME: _____

Date: _____

I hereby request and consent to the performance of massage therapy, acupuncture and/or nutrition therapy and other complementary medicine procedures by the practitioners at LifeThyme Wellness.

I understand that the massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation. I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. The massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this massage therapy is not a substitute for medical examinations and/or diagnosis. However, since a massage therapist must be aware of existing physical condition, I have stated all my known medical conditions, and will keep the massage therapist updated on my physical health. _____ (please initial)

I understand that acupuncture treatments may include, but are not limited to: acupuncture, moxibustion, acupuncture injection therapy, cupping, moving cupping, electrical stimulation, Tui-Na (Chinese Massage), Chinese or Western herbal medicine, vitamin & herbal supplement recommendations, therapeutic exercise protocols, nutritional therapy and lifestyle coaching. Acupuncture attempts to normalize physiological functions, to modify the perception of pain, and to treat certain diseases or dysfunctions of the body. I have been informed that acupuncture and acupuncture injection therapy is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that might last a few days. There is a risk of pain or discomfort, feelings of weakness, fainting, nausea, and/or broken needles. Risk of fainting, weakness and nausea are increased with an empty stomach, alcohol or drugs. There have been very rare instances reported of infection and scarring. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping. _____ (please initial)

I understand that nutrition therapy treatments are for me to obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my overall health and wellness. I understand the purpose of nutrition therapy and the benefits and risks, if any, associated with the practitioner's recommendations. I understand that results are not guaranteed. I understand that the practitioners at LifeThyme Wellness will not dispense medical advice nor prescribe treatment. LifeThyme Wellness provides education to enhance my knowledge of health as it relates to food, dietary supplements, and behaviors associated with eating. I understand nutrition therapy is not intended for the diagnosis of any disease and is not a substitute for medical diagnosis, treatment, and/or care of a disease by a medical provider. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe and LifeThyme Wellness uses only the highest quality physician-grade products. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform my practitioner as soon as possible. _____ (please initial)

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgment during the course of the procedure, based upon the facts then known, and act in my best interests.

I understand that the practitioners and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my consent. I understand my patient records and patient information will be kept confidential and shared only when necessary to provide care and services, or by my authorization, or when required or permitted by law. I understand that my practitioner(s)/or owners of LifeThyme Wellness may terminate treatment at any time.

I have read, or have had read to me, the above consents. I have also had an opportunity to ask questions about the content of this agreement.

I, _____, have read and fully understand the above statements. All questions regarding the practitioners' objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept treatment care under these terms.

Signature _____

Date _____