SAGE

Pain & Recovery Alternatives

PERSONAL STRETCH RECOVERY

First Name_____ Last Name_____ Gender_____
Address_____ City/Zip_____
Phone_____ Date of Birth_____
Email_____
Emergency Contact Name & Phone_____
Referred by:_____

All information will be kept confidential. Are you under a health practitioner's care at this time (including physician, chiropractor, physical therapist, psychotherapist, alternative practitioner, etc.)?
If yes, for what condition?_____
Are you taking any medications?_____ If yes for what?_____

Do you have now, or have you ever had, any of the following?

- ☐ Heart Disease High
- ☐ Blood Pressure
- ☐ Anemia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Diabetes
- ☐ Low Blood Sugar
- ☐ Phlebitis
- ☐ Blood Clots
- ☐ Kidney Disease
- ☐ Liver Disorder
- ☐ Hernia
- ☐ Ulcers
- ☐ Diverticulitis
- ☐ Thyroid Disorder
- ☐ Neck/Back Problems
- ☐ Paralysis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Allergies
- ☐ Cancer
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV
- ☐ Severe Depression

Have you been bothered with any of the following in the last 6 months?

- ☐ Chest Pains
- ☐ Chronic Bronchitis
- ☐ Sinusitis
- ☐ Head Colds, Flu, Fever
- ☐ Dizziness
- ☐ Dental Problems
- ☐ Urinary Disorder
- ☐ Are you pregnant?
- ☐ Do you wear contacts?
- ☐ Muscle Cramping
- ☐ Lack of Coordination
- ☐ Swollen Ankles
- ☐ Loss or Gain in Weight
- ☐ Bruise Easily
- ☐ Abdominal Pain
- ☐ Recurring Indigestion
- ☐ Constipation/Diarrhea
- ☐ Varicose Veins
- ☐ Depression
- ☐ Frequent Headaches
- ☐ Eye Strain
- ☐ Menstrual Problems
- ☐ Skin Disorder
- ☐ Inflammation (tendonitis, bursitis)
- ☐ Open sores/wounds

Have you had assisted stretching before?

What healthy lifestyle/stress reduction activities are you currently practicing?

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Describe any other present conditions, symptoms, or diagnosed diseases that you have at this time:

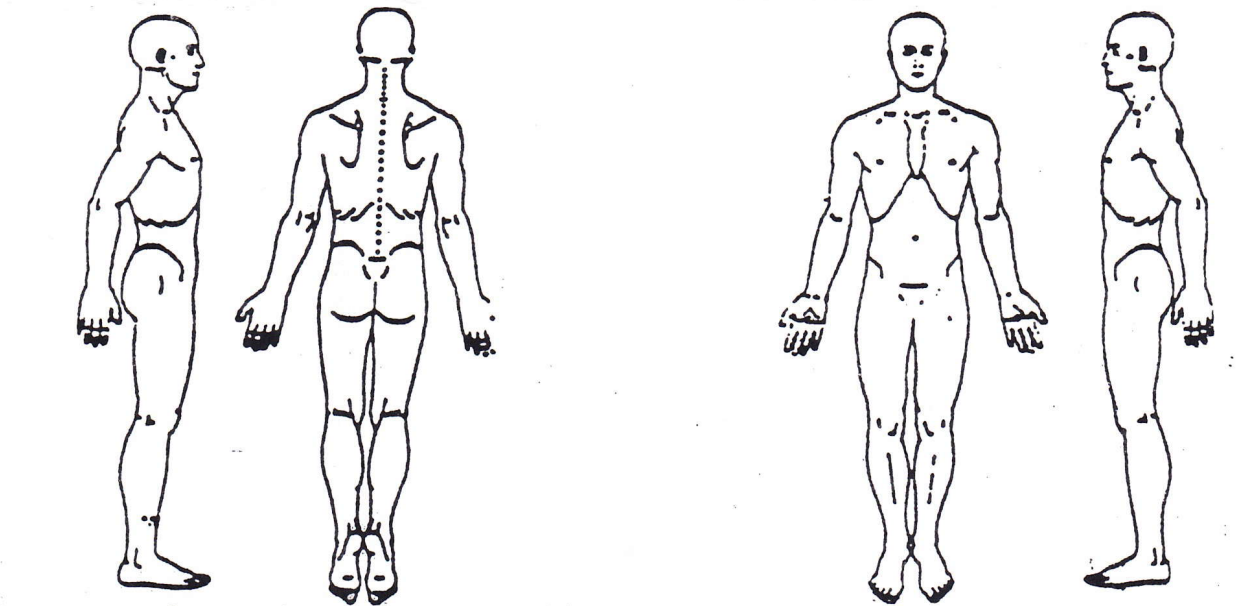
Describe any significant bodily injuries that you can remember and when they happened (like accidents, sprains, falls, bone fractures, other):

List hospitalizations and surgeries:

Do you have a condition that you want addressed by assisted stretch? (Describe condition)

What are your goals/expectations for assisted stretching? (specific issue addressed, relaxation, posture, increased range of motion, etc.)

On the figures below, please mark or shade in any areas of muscle or joint pain or stiffness.



I am requesting services on my own initiative and I realize that stretch specialists do not diagnose ailments or prescribe treatments and that the request for the information above does not imply, in any way, the practice of medicine or diagnosis of a client's condition by the stretch specialist. I, therefore, release the stretch specialist from any liability for claims resulting from the use of their services.

SIGNATURE_____ DATE_____

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AUTHORIZATION FOR ASSISTED STRETCHING

I, _____, request and consent to the performance of assisted stretching therapies by Sage Health Group, LLC doing business as Sage Pain & Recovery Alternatives.

I understand that assisted stretching is not intended to replace conventional medical treatment and that any diagnosis of my condition(s) must be performed by a licensed physician, chiropractor or physical therapist.

I understand that stretching involves the physical manipulation of muscles to address stiffness, pain, and range of motion issues. I may be asked to remove outer clothing like jackets and shoes, but I will never be unclothed during a session. I understand that the stretch specialist may use equipment during my session, such as a 'massage gun' or stretch bands.

I realize there are risks and potential side effects caused by stretching including bruising and muscle soreness. Usually side effects dissipate within 48 hours. I do not expect the stretch specialist to be able to anticipate and explain all risks and complications, and I wish to rely on the stretch specialist to exercise judgment during the course of my session which he or she feels, based upon the facts known, is in my best interest. I will immediately notify Sage Pain and Recovery Alternatives of any negative side effects or problems that I experience.

By signing below, I acknowledge that I have been told the potential risks associated with massage and I have had the opportunity to ask questions. I intend for this consent and release to cover the entire course of my treatment for my present condition and any future condition(s) for which I seek treatment. With this knowledge, I voluntarily consent to the above procedures realizing that no guarantees have been made to me by Sage Pain and Recovery Alternatives or any individual person regarding the improvement of my injury or condition(s).

I understand that any fees for treatment are payable at the time service is rendered.

I agree to give **24 hours notice** if I need to cancel an appointment. I understand that without advance notice, Sage Pain and Recovery Alternatives reserves the right to charge me a $50.00 fee for the missed appointment. Insurance companies will not reimburse me for missed appointments. Exceptional circumstances will be considered.

_____ _____

Signature of Patient Date

_____ _____

Signature of Person Authorized to Consent Date

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7116-C Six Forks Rd., Raleigh, N.C. 27615

Authorization for disclosure of health information and direct contact

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, we understand that we have, and always will, respect the privacy of your health information.

Disclosures of protected health information

Listed below are several reasons for having to use or disclose your PHI (personal health information)

- We may have to disclose your information to another healthcare provider or hospital should we refer you to them for a diagnosis, assessment, or treatment of your health condition.
- We may have to disclose PHI and /or billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your PHI within our practice for quality control or operational purposes.

Your right to limit uses of disclosure

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your PHI, we will respectfully request that you submit these restrictions in writing. With your right to restriction, you also have the right to revoke your authorization or consent to us at any time. Again, this change of authorization is requested in writing before your file status will be changed.

ESTABLISHED PATIENTS: We have a more complete notice that provides a detailed description of how your information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520) and is available upon your request. Please sign below to confirm this for has been gone over with you.

NEW PATIENTS: In your packet of new patient information you will find our Notification of Patient Privacy Policy. Please sign below to confirm that you have received it.

Authorization and permission

In general, the HIPAA privacy rule gives individuals the right to request a restriction on used and disclosures of their PHI. The individual is also provided the right to request confidential communications, such as reminders of appointment times, follow up of health care, insurance coverage's/benefits issues or any other information that only the patient will personally be able to answer.

Below, please authorize any person(s) that we may discuss your treatment/finances with or that we may release your medical records to. Those listed below will also have your permission to schedule or change appointments on your behalf as needed.

Person 1:_____

Person 2:_____

Is there a way you would prefer for us **NOT** to contact you? yes/no
If you circled yes, please let us know how **NOT** to contact you: _____

Patient Signature_____Date_____

Print Name_____DOB_____Chart #_____