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?

____

www.SAGEHealthGroup.com

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________________

www.SAGEHealthGroup.com

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

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 #**_______________