## Patient Information :: Intake Form :: Healing Waters Clinic Confidential-Please Print Clearly

## Massage clients fill in top of form only!

		Date
Phone: Home	Work	Pager/Cell
Local Address		City
State	Zip Code	
2nd Address (Out of Sta	ate)	City
State	Zip Code	
Date of Birth	Age M F	Marital Status
No. of children	Occupation	
Are you pregnant?	Which trimester	Due date
Name of attending phys	ician	
Other doctors (include ch	niropractors, specialists, etc.)_	
Referred by		Do you have a lawyer?
		Drive By Advertisement Are you on Facebook?
	Pain Relief, Herb, Nutrition	on clients fill out the rest of form.
Reasons for your visit to our		than one reason): Pain Relief
•	office (you may check off more	
Stress Reduction	office (you may check off more Healt	than one reason): Pain Relief
Stress Reduction	r office (you may check off more HealtPersonal Growth	than one reason): Pain Relief th EducationPregnancy Massage
Stress ReductionRehabilitation from trauma_Adjunctive or Complemental	r office (you may check off more Healt Personal Growth ry care for such medical condition	than one reason): Pain Relief th EducationPregnancy MassagePsychotherapeutic Support
Stress ReductionRehabilitation from trauma_Adjunctive or Complemental Postural, Structural or Cons	r office (you may check off more Healt Personal Growth ry care for such medical conditionstitutional Assessment C	than one reason): Pain Relief  th EducationPregnancy Massage Psychotherapeutic Support  ons as cancer, MS, Parkinson's, etc
Stress Reduction Rehabilitation from trauma_ Adjunctive or Complemental Postural, Structural or Cons Weight Loss & Managemer	r office (you may check off more Healt Personal Growth ry care for such medical conditionstitutional Assessment Cont Cont Cont Cont Cont Cont Energy Healing	than one reason): Pain Relief  th EducationPregnancy Massage Psychotherapeutic Support  ons as cancer, MS, Parkinson's, etc  Children & InfantsSports Massage

On the back of this page you can list other symptoms. Recent accident? What was the Date of Injury?\_

Laurence Layne, LMT, CNMT, EWCH Healing Waters Clinic & Herb Shop 26 Clark St. St. Augustine, Florida 32084 904-826-1965

## Notice of Privacy Practices (HIPAA form)

The privacy of your medical information is important to us. We create a record of the care and services you receive at our clinic. Any other personal information you disclose to us is also confidential.

You have a right to a copy of our Notice of Privacy Practices. We reserve the right to revise our Notice of Privacy Practices at any time. and a revised copy is available at our office.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the letterhead above.

<u>For Treatment</u>: We may use health and medical information about you to provide you with natural healing treatment or services. We may disclose information about you to doctors, nurses, technicians, or other health practitioners to assist them in treating you. As an example, your doctor may call us or we may write a report to your doctor.

<u>Communication</u>: In serving you, we may have to contact your home by phone, mail, or Internet to confirm appointments, or discuss your care. We will not leave personal information on your message machine.

<u>Billing</u>: We may have to send treatment notes (SOAP notes) to insurance companies. They may send you copies of bills with medical information.

<u>Legal</u>: We may have to release office notes to lawyers if you are involved in a legal case.

<u>Governmental Agency</u>: Under certain circumstances we may have to disclose information to a governmental agency, law enforcement, or to a court or administrative body through subpoena.

We are giving you this notice because it is required by law. We have always had strict confidentiality practices at our clinic to ensure our patients privacy. If you have any questions about this Notice of Privacy Practices please ask us. By signing this form you are giving your consent for us to use your medical information in your treatments.

Signature of Patient or Legal Guardian	
Patient's Name-Please Print	
Guardian's Name-Please Print	
Date	