Sarah Dible, PT. Location: ***Flourish a SPACE for Dimensional Healing***
300 East 24th Street. Vancouver, WA 98663
P: 360-798-7645 F: 360-553-4165 - rejuvenancetherapy@gmail.com REJUVENANCE.COM

Nambudripads Allergy Elimination Treatment - PATIENT REGISTRATION:

Name: First, Middle, Last Name:_____

Nickname:_____DOB:____ /_____/_____

Your Address:_____

City:_____State:_____Postal Code:_____

Phone:_____email:_____

NAET is alternative medicine and is a **Cash Pay** or "Time of Service" treatment only. See fees below:

First Visit "**Evaluation**": Establish treatment plan, goals and provide first NAET treatment.	45-60 minutes*	$140
"Follow-up" This treatment provides you thorough and complete NAET treatment and allows time for further home and self-care education/review and to address more in depth treatment options.	15-30 minutes*	$70
Follow up "**Re-assessment**" or "**Blended skill**" treatment option. This treatment option is to provide time to re-test after the first 10-15 visits or re-assess a long list of items, it is also an option for treatments where someone would like to have an NAET visit and other helpful treatments like Craniosacral Therapy, Physical Therapy, Reiki, or other energy work.	45/60 minutes*	$95/$120

*treatment duration may vary from visit to visit depending on item treated during visit.

Signature:_____Date:_____

Patient Printed Name:_____

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NAET® Treatment Consent Form

I,_____, certify that Sarah Dible, MSPT/NAET® practitioner did not claim to cure any illness or disease with NAET® (Nambudripad's Allergy Elimination Techniques).

I understand that NAET® is not a medical diagnostic procedure therefore does not diagnose any disease. Rather, NAET® gives the practitioner an indication as to the substance(s) to which the patient may have sensitivity. NAET® uses various, standard medically proven diagnostic measures and modalities (Allopathic, Chiropractic, kinesiological and Acupuncture) to diagnose the patient's condition. The premise behind NAET® is to desensitize a patient to a substance(s) using Allopathic, Chiropractic, acupuncture/acupressure, nutritional, and kinesiological principles so that the patient may not experience hypersensitive symptoms when they have future contact with them.

I understand that I am (my ward) to continue all medications and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. During the 25 hours or after if I (my ward) get a life-threatening reaction from the allergen I (my ward) was treated or from some other sources, I need to seek emergency help immediately from a physician qualified in emergency treatments, or by calling 911 or attending an emergency room at the local hospital. If I (my ward) am suffering from severe allergic reactions to substances, I should consult an appropriate physician and take appropriated medication (such as medication to prevent itching, tissue swelling, fever, cough, pains, infections, mental irritability, violent behaviors, etc.) to keep my (my ward's) symptoms under control while I (my ward) am treating with NAET® treatments. This way, essential NAET® treatments can be completed without interruption and once I (my ward) complete the essential NAET® treatments for my (my ward's) condition, I (my ward) may not need to continue pharmaceutical drugs indefinitely.

I understand that for 25 hours after the treatment I (my ward) am to avoid eating, touching, breathing and coming within 5 feet of the substance(s) that I (my ward) have received treatment. If I (my ward) come in contact with substance(s) for which I (my ward) am being treated, I realize that the treatment may not work and I (my ward) may have a sensitivity reaction.

I understand that I (my ward) must return after my 25 hours avoidance period preferably within 7 days, to see if I (my ward) have cleared for the substance(s). I fully understand that I (my ward) may still experience a reaction to the substance(s) of unknown severity if I (my ward) come in contact with them if I (my ward) did not clear them completely. If I (my ward) did not clear them completely, I (my ward) may be required to repeat the procedure (more office visits at my cost) until I (my ward) clear them satisfactorily.

I understand that this document will be filed in my records and will apply to my initial session as well as all additional sessions.

I have read or have had read to me the above statements and have had the opportunity to ask questions about its content and by signing below I agree to the terms and procedures.

_____

Patient's Signature Date

_____

Patient Printed Name:_____

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Name of the Minor Relationship to the minor (ward)

SARAH DIBLE MSPT/REJUVENANCE THERAPY PATIENT CONSENT/WAIVER:

HEALTH INFORMATION: Your personal health information, which includes your entire medical history and information about services provided to you, is protected by law. This health record serves as a basis for planning your treatment, communication between your health care professionals, legal documentation, verification of treatment for third party payers, and a tool to improve your care based on outcomes. Although this record is the physical property of the health care provider, this information also belongs to you and you have rights regarding the privacy of your records. A detailed explanation of these rights is available at the front desk and a copy is available to you upon request. In order to provide the best care possible, we may need to discuss your case with other health care professionals and health care facilities. By signing below, I authorize Rejuvenance Therapy or Sarah Dible, MSPT to release my medical records to my physician and my other health care professionals. I also authorize Rejuvenance Therapy to request pertinent medical records from these professionals (including copies of related imaging.) Please list pertinent health professionals and their contact information:

_____

_____

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. By signing below, I agree that I have been informed about this privacy practice and my protected health information and how to obtain a personal copy of this form and privacy policy.

CONSENT TO TREAT: You are an important partner in your health care decisions and play an active role in the outcome of your medical care. Thus, it is important that you are informed about benefits, risks, evaluations, and decisions about your care while being seen at this office. If you have questions, symptoms, or problems related to your care it is your responsibility to notify your physical therapist and consult with your primary care provider as necessary.

CREDIT AND PAYMENT POLICIES: Our goal is to provide you with the highest quality care at a reasonable cost. Cash-pay patients will be expected to pay for services in full at the conclusion of their appointment.

PATIENT MISSED APPOINTMENT POLICY: We are committed to fully assist you with your rehabilitation needs and thus, you are expected to attend all of your appointments. We are reserving this time specifically for you. If you need to cancel or reschedule an appointment, please do so 24-hours prior to your appointment time. A $25 fee will be charged for sessions missed without such prior notification. This fee will be due prior to your next treatment (insurance is not responsible for this fee.) All cancellations and no shows are documented in your medical record. We understand there are occasional emergency situations and we appreciate your consideration of our time. In instances of repeated non-compliance with scheduled visits, we reserve the right to discontinue care. By signing below, you agree to this policy.
By signing below, I agree to be treated by Rejuvenance Therapy – Sarah Dible, MSPT, knowing there may be potential risks along with benefits, and I am willing to be an active participant in my own care.

Signature:_____ Date:_____

Patient Printed Name:_____

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Health History Questionnaire:

Briefly describe the problem that brings you here today: _____

_____

_____

Date the above problem started:_____

Other treatments you have had for this problem:_____

_____

Please list any known allergies and their symptoms:

_____

_____

_____

Please list any medications or supplements that you are currently taking:

_____

_____

_____

General Health History: check all that apply

[ ] Arthritis	[ ] Stroke	[ ] Fibromyalgia
[ ] Cancer: [ ] In remission	[ ] Stomach Disorders	[ ] Headaches
[ ]Diabetes	[ ] Anxiety	[ ] Hearing Problems
[ ]Heart Disease	[ ] Back Injury	[ ] Numbness or Tingling
[ ] High Blood Pressure	[ ] Pacemaker	[ ] Arthritis RA/OA
[ ] Lung Disease	[ ] Visual Problems	[ ] Allergies/Hay Fever
[ ] Allergies	[ ] Kidney Disease	[ ] Sleep Disorders
[ ] Asthma	[ ] Skin Disorder	[ ] Head Injury
[ ] Epilepsy	[ ] Osteoporosis	[ ] Fracture
[ ] Chronic Pain	[ ] Fatigue	[ ] Hernia

Current pain level:

0 1 2 3 4 5 6 7 8 9 10

No Pain Too much pain

Is your symptom [ ] Constant [ ] Increasing Decreasing [ ] Staying the same [ ] Occasional

What makes your symptom worse?_____

Prior to your symptoms or problem, what activities could you do that you are unable to do now?_____

Patient Printed Name:_____

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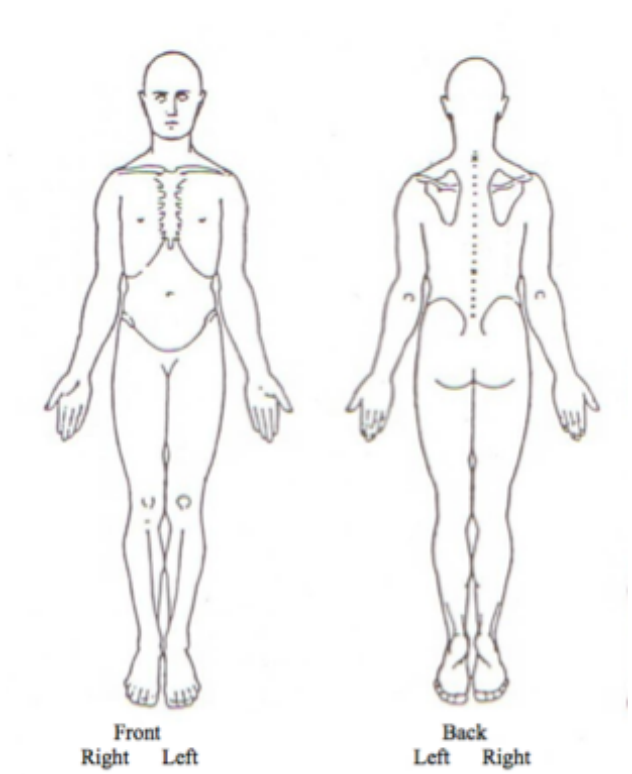
Your usual activity level: [ ] Low [ ] Medium [ ] High

Do you smoke?	[ ]Yes	[ ]No
Do you exercise regularly?	[ ]Yes	[ ]No
Do you use drugs?	[ ]Yes	[ ]No



If there are physical symptoms (ex: rash, pain etc..)
Please use this diagram to indicate your symptoms:

What are your personal goals for NAET?
1)_____
2)_____
3)_____
4)_____

Please include any other information you feel will helpful for your care:_____

Patient Printed Name:_____