HOLISTIC
Health Care Centers, LLC
Synergy & Science

Date: _____

Name: _____ **Phone #** _____ **Email:** _____

Address: _____ *(city)* _____ *(state)* _____ *(zip)* _____

Emergency Contact: *(name)* _____ *(phone)* _____ *(relationship)* _____

D.O.B _____ **Occupation** _____

How did you hear about us? _____

Have you had a theraputic massage before? Y/N _____

Are you currently under the care of a chiropractor or physican? Y/N _____

Please list any injuries or surgeries: _____

Please list any allergies or sensitivities: _____

Please list all medications you are using: _____

Please check all that apply:

☐	Headaches/Migraines
☐	Neck pain
☐	Jaw clenching/grinding
☐	Upper back pain/stiffness
☐	Lower back pain/stiffness
☐	Hip pain/stiffness
☐	Legs/Knees pain/stiffness
☐	Varicose Veins
☐	Diabetes
☐	High Blood Pressure
☐	Arthritis
☐	Fibromyalgia
☐	Blood clots

Do you experience any numbness or tingling? If so, where?

_____

What kind of pressure do you prefer? (Deep, medium, light)

_____

Are you sensitive to fragrances/essential oils? Y/N _____

Do you suffer from chronic pain? Y/N _____

If yes, what makes it better? _____

_____

What makes it worse? _____

_____

Please list any areas you would like to focus on today: _____

_____

Informed Consent

I voluntarily consent to be treated by Holistic Health Care Centers, LLC. The center offers several treatment modalities. The course of the treatment will be determined between the health practitioner and myself.

_____ I understand that there is neither an implied or stated guarantee of success of effectiveness of a specific treatment or series of treatments. I understand that all my questions regarding the procedure will be answered, and that I am free to withdraw my consent and discontinue treatment at any time.

_____ I hereby authorize Holistic Health Care Centers, LLC to release any information regarding my condition(s) to the referring physician (if any) and/or to my insurance for the processing of any claim. With notification, I also authorize Holistic Health Care Centers, LLC to obtain my medical records from other physicians or medical centers.

_____ Payment in full is expected at the time of each appointment. If charges are being submitted to insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this provider.

_____ I agree to give 24 hours notice to the Holistic Health Care Centers, LLC if I must cancel or reschedule an appointment. I understand that I will be charged Holistic Health Care Centers, LLC current clinical rates after the first (1) missed appointment when no notice is given or for failing to show up to the appointment. Exceptions may be made in the case of an emergency. I understand that in the case of unavoidable lateness of more than 15 minutes by me, the scheduled appointment may be adjusted or rescheduled. I understand if I am more than 15 minutes late to my appointment, the appointment may be shortened or rescheduled and I may be charged for the missing appointment. I understand that if Holistic Health Care Centers, LLC is experiencing unavoidable lateness of more than 15 minutes into my appointment, if possible, they will notify me and I have the choice to cancel without charge.

Thank you for your cooperation and consideration.

Signature_____

Date _____

Patients Representative or Parent _____

Holistic Health Care Centers
3033 Ogden Ave. Suite 302
Lisle, IL 60532
(847) 571-5455 www.hhcc.co

HOLISTIC
Health Care Centers, LLC
Synergy & Science

Acknowledgment of Receipt of Privacy Practices for Holistic Health Care Centers, LLC

I have received a copy of the document titled:
HIPAA Privacy Statement Healing Paths of Privacy Practices

All of my questions have been answered and I have been given a copy of this document.

Patient Printed Name _____

Patient Signature _____

Parent/Guardian Signature for Minor _____

Relationship _____

Telephone Number _____ Date _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE