Welcome to the Center for Living Health, as a new patient of Linda Lazar Allen, CAMT.

The Center for Living Health was founded by husband and wife team Michael Allen MD and Linda Lazar Allen CAMT. Together they created a heart centered practice that consciously strives to bring balance, strength and optimal health to the whole person by integrating conventional and holistic medicine and therapies. We look forward supporting you in a more balanced approach to health.

Enclosed is our new patient form for Linda. This packet contains notices and agreements that need to be read and signed before your first appointment. Please be sure to complete this form ahead of time and bring it to your visit.

Please read through our cancellation policies and be aware of your commitment as a patient of our practice. Missed appointments are costly and take away valuable appointment time from others.

We are located in Gold River just east of Sacramento at 11344 Coloma Road (off of Sunrise Blvd near Hwy 50), in the Regents Park Office Complex. Our office is in building 400 in the rear center portion of the complex, Suite 445 on the lower level. You may want to plan on arriving early to account for difficulty finding the office, traffic, etc.. (see our website for complete directions).

Our team of providers and support staff at The Center for Living Health are committed to providing you with the highest level of personalized integrative care and working together with you as partners in your health and healing.

Again, welcome to the Center for Living Health. We look forward to seeing at your upcoming appointment.

11344 Coloma Rd, Ste 445, Gold River CA 95670
main office 916.803.7040 tel 916.852-7041 fax Linda Allen 916.452.9440

Office Practices and Policies

Patient Hours

We schedule Patient visits Mondays, Tuesdays, Wednesdays and Fridays from 9:30-5pm.

Cancelling Appointments/Missed Appointments

- Appointment changes with Linda must be at least 2 business days prior to your scheduled appointment.
- Charges for missed appointments/late notice for Linda are $75.
- Patient agrees to pay all late cancellation and missed appointment fee's.

PPO Insurance

We are an out of Network provider, which means we do not participate with any insurance company. All patients must pay at time of service for their care. We will provide you with an invoice that has coding to submit to your insurance company. We are not responsible for any claims that are unpaid or rejected.

Website and Facebook:

Complete information about our practice and all relevant patient forms are on our website: www.centerforlivinghealth.com. Also please follow us on Facebook for office updates and information https://www.facebook.com/centerforlivinghealth/

Unpaid Balance Fees

I understand and agree to pay Overdue/Unpaid Balance Fee's as follows: 1) 10% unpaid balance fee applied to all balances 30 days past due. A second 10% fee will be applied to all balances 60 days overdue . 2) Unpaid balances past due 90 days will be sent to collections and a 50% collection fee will be applied to your account.

Our Notice of Privacy Practices

Private controlled use of your information by staff is essential to your care. Patient Understands and Agrees That By Signing the New Patient Form: .

- Patient consents to CFLH's use and disclosure of protected health information about you for treatment, payment & health care operations (TPO)
- Patient consents Center for Living Health staff to call, text, email and leave messages on voice mail that assist the practice in carrying out TPO such as appointment reminders, statements and calls pertaining to my care, using the address or numbers I provide.
- Copy of our Privacy Practices is available on our website or in our office.

Linda Lazar Allen Fee's

New Patient Appointment: $125
CST Appointments (40-45 min) $95
HCT Appointments (1 hr) $125 – (double or longer scheduled sessions will be prorated)

Craniosacral Therapy/Emotional Healing
Pediatric Patient Form

Appointment Confirmation Best Contact:

Email Address_____ **Phone #**_____ ❒ Okay to send text confirmation to #

Child's Name _____ ❒Female ❒Male
First *MI* *Last*

MailingAddress_____City_____State_____Zip_____

Date of Birth: _____ Age____ School Grade_____ School _____

Parent Name _____ Occupation _____

Parent E-mail_____Parent Phone: _____ ❒Home ❒Work ❒Cell

Parent Name _____ Occupation _____

Parent E-mail_____Parent Phone: _____ ❒Home ❒Work ❒Cell

Parent's are ❒Married ❒Separated ❒Divorced ❒Living Together ❒ Deceased - how old was child when parent died _____

Are parent's listed the Biological parents of the child? ❒ Yes ❒ No

Siblings *(Names and Date of Birth)* _____

_____

Parent/Legal Guardian Address (if different than child) ❒ Mother ❒ Father

Address_____City_____State_____Zip_____

Who may we thank for referring you/how did you hear of our practice? _____

Consent for Care

I have completed the attached form to the best of my knowledge and will inform my therapist about any change in my child's health. I understand the bodywork and somatic therapy being given is for the well being and balance of body, mind and spirit. This includes stress reduction, relief of emotional and physical connective tissue restrictions, spasm or pain. I realize that bodywork should not be construed as a substitute for medical examination, diagnosis or treatment, and that nothing said in the course of action should be construed as such. Additionally, I acknowledge and confirm that I fully understand that the particular therapeutic outcomes of these treatments, individually and cumulatively, cannot be predicted with certainty and no guarantee is made regarding my result or outcome.

I have read this entire form and policies and fully understand it and agree to abide by its terms. I understand that Insurance may not pay for these services and I agree to pay for all services in full at time of visit. I agree to accept the fee charged for missed appointments and services charged for unpaid bills should such be necessary, as outlined in the policies in the packet. I also understand and agree that a $35.00 fee will be charged for returned checks I waive now and forever, my right of exemption under the laws of California.

I have read to and consent to all the office practices and policies outlined on these forms.

Parent or Guardian Name_____ Signature_____Date_____

Please take your time filling this out. The more complete you are, the more we may be able to help you.

Child Name_____ Date of Visit_____

Reason for Visit_____
_____

_____

Child's present emotional health/disposition

_____

_____

List any physical trauma (broken bones, stitches, accidents) that have taken place and age of child at the time

_____

_____

Please list any emotional trauma, stress or major changes that the child has experienced

_____

_____

Does child have any other medical conditions I should know about _____
_____

Sleep Pattern
❒normal ❒ difficulty falling asleep ❒frequent waking ❒nightmares ❒night terrors ❒other_____

Has child been diagnosed with ❒sensory processing dysfunction ❒ADD/ADHD ❒learning disability

❒autism/aspergers ❒other_____

If yes when and name of Doctor_____

Describe any habits of child (thumb sucking, chewing/twisting hair, nail biting, etc)

_____

_____

Excessive fears of child or activities that make them anxious: ❒water ❒being alone ❒dark ❒ night terrors
❒thunder ❒strangers ❒other- please describe _____

Does child have any sensitivity to ❒sound ❒touch ❒smells ❒lights Describe_____

Abnormal movements ❒none ❒ excessive turning ❒hand flapping ❒tics

Has child had/have ❒regression of speech ❒difficulty comforting ❒❒difficulty nursing
❒ consistently display stress or discomfort with certain activities or positions (i.e. lying on back, tummy time, diaper change, car seat, etc.) ❒difficulty concentrating ❒squirms/can't sit still

Please check if child does/did the child experience any of the following? (circle if current):

❒broken/fractured bones ❒ headaches ❒head injuries/concussion ❒ jaw pain/TMJ ❒Tend to be stiff ❒Flattening of the skull ❒ Head tilted/neck rotated to one side	❒Tight neck muscles *(Torticollis*) ❒neck pain ❒high fever ❒Colic ❒ Reflux ❒Food sensitivities or allergies	❒asthma ❒sinus problems ❒epilepsy/seizures ❒ Arching backwards or pushing away ❒Required tubes in ears	❒depression ❒constipation ❒anxiety/stress

❒Allergies; specify_____

Is child sensitive to or have allergies to essential oils? ❒Yes ❒No

Is child allergic to latex ❒Yes ❒No

Pregnancy/birth

Lbs_____ Weeks_____

Health of baby at birth _____

Post Natal Complications

❒None ❒Respiratory ❒Cardiac ❒Infections ❒Gastrointestinal ❒Hospitalized -- How long? _____

❒Colic ❒Tight neck muscles *(Torticollis*) ❒Flattening of the skull

Please note any interventions shortly after birth such as hospitalization for illness, jaundice, operations, illnesses

_____

_____

Mother's age at delivery _____ Number of Pregnancies_____ Number of Live Births _____

Where is child in birth order (if other siblings list ages)_____

Please describe Mother's Pregnancy/birth (planned, problems, high risk, emotions, concerns, expectations, stresses/trauma your life during pregnancy, etc..)

_____

_____

Please describe delivery (vaginal, C-section, forceps, length labor, complications etc..)

_____

_____

Did you breast feed ❒Yes ❒No Until what age _____

SIGNATURE_____NAME_____

RELATIONSHIP TOPATIENT_____ DATE_____