



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 Sacramento at the SE corner of Howe Avenue and Northrup. Our office in the rear of the building on the south side, Suite 370.. 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.

800 Howe Avenue, Suite 370 Sacramento CA 95825
main office 916.803.7040 tel 916.852-7041 fax Linda Allen 916.452.9440
www.centerforlivinghealth.com patientinfo@centerforlivinghealth.com



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 (@35-40min) \$95

HCT Appointments (@50-60min) \$125 – (double or longer scheduled sessions beyond an hour will be prorated)



Craniosacral Therapy/Emotional Healing Adult Patient Form

Date _____ How did you hear about our practice _____
Name _____ Birthdate _____
Address _____
City _____ State _____ Zip _____
Cell Phone _____ Home Phone _____
Best phone to call _____ Cell _____ Home _____ Permission to Text Appointment Reminders __Yes __No
Email _____ *(For communication and appointment information)*
Occupation _____ Employer _____
Current Relationship Status _____ How Long _____
Name of Spouse or Life Partner _____
Are any other family members patients of Dr. Allen? __Yes __No If yes
Names _____

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 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.

Name _____ Signature _____

Relationship to Patient *(if other than patient)* _____ Date _____



Craniosacral Therapy Patient History

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

Name _____

Date of Visit _____

What are your primary concerns Physical Emotional/Stress Both

Please explain _____

What do you believe caused your symptoms:

What gives you relief? _____

Are there any factors you feel are impacting your ability to heal? _____

Have you been seen by any other health care professional for these issues? Yes No (If yes please provide name and type of care)

Please check if you have had a recent: MRI X-RAY Other diagnostic tests _____

List any physical trauma (broken bones, stitches, accidents, operations) that you have experienced.

Please list any emotional trauma, stress or major life changes that you have experienced



Please say something about your spiritual life/beliefs. Do you connect spiritually to anything greater than yourself

What do you do to nurture yourself and relieve stress:

Are you currently single married or in a long term relationship divorced separated widowed

Please describe your feeling about your relationship:

Do you have children? Yes No If yes, what are their ages _____

Please briefly describe your experience parenting (challenges, emotions, beliefs, etc...)

How do you sleep? __ Trouble falling asleep __ Wake in middle of night __sleep soundly __feel tired when awoken in morning

Please check any you have had in the past or currently experience:

<input type="checkbox"/> broken/fractured bones	<input type="checkbox"/> concussion	<input type="checkbox"/> asthma	<input type="checkbox"/> depression
<input type="checkbox"/> headaches/head injuries	<input type="checkbox"/> neck pain	<input type="checkbox"/> sinus problems	<input type="checkbox"/> anxiety/stress
<input type="checkbox"/> low back, hip, leg pain	<input type="checkbox"/> headaches	<input type="checkbox"/> epilepsy/seizures	<input type="checkbox"/> heartcondition
<input type="checkbox"/> shoulder, arm pain	<input type="checkbox"/> migraines	<input type="checkbox"/> arthritis	<input type="checkbox"/> emotional imbalance
<input type="checkbox"/> jaw pain/TMJ	<input type="checkbox"/> chronic Fatigue	<input type="checkbox"/> digestive problems	
<input type="checkbox"/> numbness/tingling	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> vertigo/dizziness	
<input type="checkbox"/> other _____	<input type="checkbox"/> vision/eye problems		



Holistic, Anthroposophic & Traditional Pediatrics

Pain : sharp shooting burning ache dull
other _____

Is this problem: always present comes and goes
If it comes and goes, how long does each episode last? _____

How many episodes per day or month? _____

Is it worse in the: morning evening night

What makes it worse: sitting standing walking
other _____

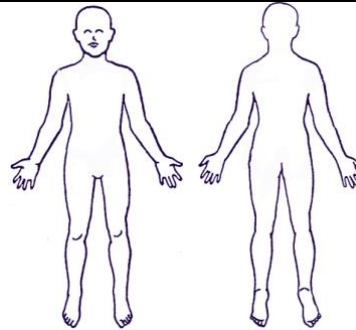
Does pain interfere with your normal daily activities? Y N

Does it make it difficult for you to sleep? Y N

allergies; specify _____

Are you sensitive to or have allergies to essential oils?

Are you allergic to latex



Please mark on figures above any pain, numbness, tingling or spasms.

YOUR CHILDHOOD

Did you feel safe growing up? Yes No Please briefly describe your childhood:

Describe your relationship with your parents and family from childhood to the present _____

Any other information that would be helpful in your treatment or care

Women Only:

Have you ever been pregnant? Yes No If yes, how many times _____

Please describe experience pregnancy/birth: _____

Have you ever lost a child to miscarriage, abortion, stillbirth or death? Yes No

If yes, please explain circumstances,
