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).*

Also, all of our patient correspondence is by email, so please be sure to check your spam. It is your responsibility to make sure you are receiving our emails in your inbox.

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
www.centerforlivinghealth.com patientinfo@centerforlivinghealth.com

Office Practices and Policies

Patient Hours

We schedule Patient visits Mondays, Tuesdays, Wednesdays and Thursdays 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.

Patient Nondiscrimination Policy

Equal care will be provided to all patients, regardless of age, race, ethnicity, physical ability or attributes, religion, sexual orientation, gender identity or gender expression.

Website and Facebook:

Complete information about our practice and all r patient forms are on our website: www.centerforlivinghealth.com.

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.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contain a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this consent (Notice available in office or on our web site). Patient Understands and Agrees That

By Signing This 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.
Practice may take a picture of patient to be placed in medical record

My signature below indicates I have reviewed the CFLH Notice of Practice of Privacy (on website or available in our office) and fully understand its terms, including my responsibilities and assumed risks. I herby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.

Responsible Party Signature_____ Date_____

Patient Consent to Use of Telemedicine

By signing this form, I understand the following:

> I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I have read and understand the information provided above regarding telemedicine. I hereby authorize Center for Living Health practitioners to use telemedicine in the course of my diagnosis and treatment when I request it.

Signature of Patient (or parent if under 18):_____ Date: _____

If authorized signer, relationship to patient: _____

Craniosacral Therapy/Emotional Healing Pediatric Patient Form

Appointment Confirmation Best Contact:

Email Address_____ **Cell Phone #**_____ ☐ Allow SMS Text Reminder

Child's Name _____Date of Birth: _____ Age____
First *MI* *Last*

Gender Identity: _____ Assigned Sex at Birth ☐ Femaie ☐ Male

Preferred Pronoun: ☐ She/Her/Hers ☐ He/Him/His ☐ They/Them/Theirs ☐ Other_____

School Grade_____ School _____

MailingAddress_____City_____State_____Zip_____

Parent/Guardian Name _____ Occupation _____

Parent/Guardian Name _____ Occupation _____

Parent(s) are ☐ Married ☐ Separated ☐ Divorced ☐ Deceased ☐ Single ☐ Other _____

If deceased, age of child when lost parent _____

Are parents listed the Biological parents of the child? ☐ Yes ☐ No If no, relationship to child_____

Siblings *(Names and Date of Birth)* _____

_____

Parent/Legal Guardian Address (if different than child) Parent Name:_____

Address_____City_____State_____Zip_____

Please list one person not living with you to contact in case of emergency:

Name: _____Relationship _____Phone Number _____

Address_____City_____State_____Zip_____

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

Waiver of Liablity: I authorize the release of medical information to my referring doctor and all providers at the Center for Living Health. I understand that all fees are due at time of service, and The Center for Living Health is not responsible for any claims unpaid or rejected. 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.

Parent /Guardian Name _____ Relationship to Patient_____

Parent/Guardian Signature_____ Date _____

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

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

Child Name_____ **Date of Visit**_____

What is your primary concern ___Physical ___Emotional/Stress ___ Both

Please explain_____

_____

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

_____

_____

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

_____

_____

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

_____

Please briefly describe spiritual beliefs, family rhythms, and/or other information that can help paint a picture of your family. _____

_____

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/focus ❒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_____

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 _____

Any breastfeeding issues (latch, pain, etc..)_____