Welcome to

Blue Orchid Holistic Wellness Clinic

We are pleased to welcome you to our practice.

Please take a few minutes to fill out these forms. If you do not know the answer to a question, please say I don't know or something similar.

These questions are here so that I may truly help you in all areas of your life.

We look forward to working with you to maintain a Healthy You.

Patient Information

Full Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip Code: ________

Home Phone #: ____________ Cell Phone #: ____________

Email: ____________________

Sex: ☐M ☐F Age: ______ yrs. old Birthdate: ___/___/___

Relationship Status: ____________ Their Name, if applicable: ____________

Children's Name(s), if applicable: ____________________

Others living with you, including pets: ____________________

Employer & Occupation: ____________________

In case of Emergency, Notify

Name: ____________________

Relationship: ____________ Contact #: ____________

What Services Are You Interested In?

Check the box, with the service that you are interested in.

- ☐ Wellness Consultations
- ☐ Aroma Wrap
- ☐ Crystal Massage
- ☐ Reiki Therapy
- ☐ Supplement Nutrition
- ☐ Relaxation
- ☐ Organic Whole Food Nutrition
- ☐ Chemical Free Skin Care
- ☐ Chemical Free Home Care Products
- ☐ Stress Management
- ☐ Life Coaching
- ☐ Financial Coaching
- ☐ Other: ____________________

Who may We Thank for Referring You?

Name/Source: ____________________

How Important is Your Health to You?

On a scale of 1-10; 1 being least important & 10 being your highest priority.

1 2 3 4 5 6 7 8 9 10

Medical History

Check the box, with the condition that you have.
Please use the space below to write any other conditions not listed.

- ☐ Anxiety
- ☐ Asthma
- ☐ Breathing Problems
- ☐ Bowel/Bladder Problems
- ☐ Cancer
- ☐ Circulatory Problems
- ☐ Chronic Pain
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Problems
- ☐ Dizziness/Fainting
- ☐ Eczema
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heart Attack/Stroke
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Immunity Problems
- ☐ Joint Problems
- ☐ Kidney Problems
- ☐ Liver/Gallbladder Problems
- ☐ Memory Loss/Forgetfulness
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Palpitations
- ☐ Pace Maker
- ☐ Ringing in the Ears
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Skin Conditions
- ☐ Surgical Implants
- ☐ Thyroid Condition
- ☐ Weight gain or loss

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Do you participate in any of these activities?

☐ Alcohol ☐ Cannabis ☐ Smoke Cigarettes ☐ Vape ☐ Other:______________

How Much/Often:______________________________

Accidents & Surgeries

Please use the space below to write any previous accidents that required hospitalization or rehabilitation therapy, surgeries and any other hospitalization.

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Family History

Please use the space below to write any pre-existing family conditions.

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Allergies

What allergies or sensitivities do you have?

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Current Medications & Supplements

Medications with mg per day	Supplements with mg (or g, iu, etc.) per day

Beauty & Skincare Products

What are the name brands of the beauty, hygiene and skincare products that you currently use?

Cleaning Products

What are the name brands of the cleaning (kitchen, bath, etc.) and laundry products that you currently use?

Organic Food

Do you currently use organic, whole food, or all natural food products? If so, how often?

Exercise Routine

What type of exercise do you currently partake in? How often?

Relaxation Routine

What type of relaxation or stress relief do you currently partake in? How often?

Financial Overview

What is the state of your finances? How is your money being spent every month?

If you would like help with this section, please write "would like to do budget" and we will devote a session to just your finances.

Life Coaching

Is there any other area of your life that you need help with? Relationships, spiritual, etc.?

Additional Notes

Please use this space to add anything else not already covered
or to continue a topic if not enough room was provided above.

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Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the Blue Orchid Holistic Wellness Clinic and its Health Professional(s), to help determine an appropriate and helpful holistic treatment plan.
If there are any changes in my medical status, I will inform the Health Professional.

x____________________ x____________________ ____________________
Print Name Sign Name Date

Confidentiality Agreement

It is understood and agreed to that the below identified discloser of confidential information may provide certain information that is and must be kept confidential. To ensure the protection of such information, and to preserve any confidentiality necessary under patent and/or trade secret laws, it is agreed that:
The Confidential Information to be disclosed can be described as and includes:

- All personal information regarding the Wellness Member health, family, work, wealth, etc. shall never be talked about or shared to anyone by the Wellness Professional or Blue Orchid Holistic Wellness Clinic.
- Information can be shared only in third person format. (Example: I, Wellness Professional, have helped someone in a similar situation by getting them on St John's Wort for depression and got them off there prescription medication.)

x____________________ x____________________ ____________________
Print Name Sign Name Date

Which Membership Would You Like?

The Blue Orchid Holistic Wellness Clinic Membership Plan is for everyone!
This plan is open to anyone regardless of health status, pre-existing conditions and insurance status.
There are no signup fees or other hidden charges, and there are no deductibles or co-pays.

☐ Seedling

- 1 Follow Up Consult
- Unlimited Email Communication
- Access to All Services at Member Price
- Be entered into Monthly Raffle

$20/mo 1 Adult
$30/mo 2 Adults
$10/mo 13-18 yrs
$5/mo NB-12 yrs

☐ Sprout

- All from Seedling
- 1 Crystal Massage with Aroma Wrap
- 1 Reiki Treatment with Aroma Wrap

$40/mo 1 Adult
$60/mo 2 Adults
$20/mo 13-18 yrs
$10/mo NB-12 yrs

☐ Blossom

- All from Seedling
- 4 Crystal Massages with Aroma Wraps
- 4 Reiki Treatments with Aroma Wraps

$100/mo 1 Adult
$150/mo 2 Adults
$50/mo 13-18 yrs
$25/mo NB-12 yrs

*Children 18 yrs to newborn (NB) can be kept at lower rate if they do not partake in services
*Crystal Massage or Reiki Treatment can be exchanged for a Follow-Up Consultation
*Members can also gift services to non-members at the member price

Referral Program

When you are a member and refer someone who becomes a member you will receive:

- $5 off your membership (on your next bill, or you can put it towards another purchase)
- Be entered in the Monthly Raffle again!

How to Pay

Every month your membership will be due on the date that you signed up or another date that has been agreed upon. You can pay for the membership plan using PayPal or in person. We accept cash, check or credit/debit cards with our PayPal card reader. There are no late fees; however you will not have access to the member services until you pay for your membership. If you are having trouble paying your membership, please let me know I will do what I can to help you.

How to Cancel

Membership can be discontinued at any time.
Your last month's cost is non-refundable.
There are no cancellation fees.
If canceled 72 business hours before next billing cycle you will not be charged.

☐ Opt out of Membership

Office Use Only

Do not sign until payment, for future consults/sessions, has been agreed upon by both parties

Payment Agreement Notes

If opting out of membership, list the agreement for pricing on consults/sessions.
If Membership is chosen, list the pricing for each person and membership.
And any other notes needed

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x____________________	x____________________	________________
Print Name	Sign Name	Date

Payment Authorization

I understand all charges and or membership plan and accept the responsibility of those charges. Payment is due at the time of booking an appointment, unless prior agreement is made with Blue Orchid Holistic Wellness Clinic. Payment can be made in cash or by using PayPal.
Note: PayPal is free, if transfer is made online. We do have a card reader on-premises, however, there is an additional fixed fee added on depending on charges.

Membership is an automatic PayPal monthly withdrawal. If membership is chosen your withdrawal date is ______________ and amount withdrawn is $________. If changes need to be made to this, please call the office 72 business hours prior to next withdrawal date.

x____________________	x____________________	________________
Print Name	Sign Name	Date

Privacy Policy

This notice describes how medical information about you may be used and disclosed, as well as how to get access to this information. Please review this information carefully.

Blue Orchid Holistic Wellness Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations. All employees have signed a confidentiality agreement.

EMERGENCIES

We may disclose your health information to notify or assist in notifying emergency responders, in the event of an emergency. We will also notify your emergency contact provided on your new patient information form.

PUBLIC HEALTH

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

We may disclose your health information in the course of any administrative or judicial proceeding.

MARKETING

We may contact you for marketing purposes and fund raising purposes.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Blue Orchid Holistic Wellness Clinic is not required to agree to the restriction that you requested.
You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
You have the right to inspect and copy your health information.
You have a right to request that Blue Orchid Holistic Wellness Clinic amend your protected health information. Please be advised, however, that Blue Orchid Holistic Wellness Clinic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
You have a right to a paper copy of this Privacy Policy at any time, upon request.

CHANGES TO THIS NOTICE OF PRIVACY POLICY

Blue Orchid Holistic Wellness Clinic reserves the right to amend this Privacy Policy at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, Blue Orchid Holistic Wellness Clinic is required by law to comply with this notice or the last current one signed by the patient on file.

This notice is effective as of the date listed below.
I have read the Privacy Policy and understand my rights contained in the notice. By way of my signature, I provide Blue Orchid Holistic Wellness Clinic with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Policy.

X____________________	X____________________	________________
Print Name	Sign Name	Date