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 9:30-4:30pm.

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- $100 depending on the type of appointment.
- 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 Adult Patient Form

Appointment Confirmation Best Contact:

Email Address________________________________ Cell Phone #_____________________ ☐Allow SMS Text Reminders

Name ____ Birthdate___________________________

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

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

Address____

City____ State______ Zip__________________

Occupation ___________________________________ Employer ____

Current Relationship Status______________________________Name of Spouse/ Partner______________________

Are any other family members patients of Linda Allen or Dr. Allen? __Yes __No If yes

Names____

How did you hear about our practice/referred by _______________________________

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 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 $50.00 fee will be charged for returned checks.

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.

❒ Sensitive to or have allergies to essential oils? ❒Allergic to latex

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?

____

____

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

____

____

Do you feel you have any limiting self-beliefs or an inner critical voice that disempowers you? If yes, are you aware of it and how does it limit you in your life.

____

____

____

What do you do to nurture yourself and relieve stress:

___

___

___

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

___

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

Please describe your feelings 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 awaken in morning

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

❒broken/fractured bones	❒concussion	❒asthma	❒depression
❒headaches/head injuries	❒neck pain	❒sinus problems	❒anxiety/stress
❒low back, hip, leg pain	❒headaches	❒epilepsy/seizures	❒heartcondition
❒ shoulder, arm pain	❒migraines	❒arthritis	❒emotional imbalance
❒jaw pain/TMJ	❒chronic Fatigue	❒digestive problems	
❒numbness/tingling	❒fibromyalgia	❒vertigo/dizziness	
❒other___	❒vision/eye problems		

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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_____________________________________

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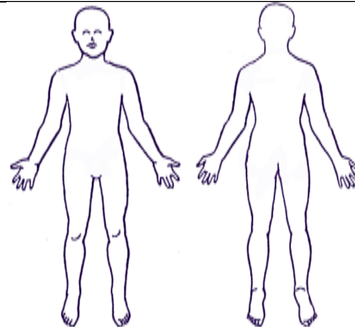

Please mark on figures above any pain, numbness, tingling or spasms.

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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,

____