Vital Waves

PEMF Therapy Session Intake Form

Name: _____ Date: _____

Phone #: _____ cell__ vm__ text__ Alt Phone #: _____

DOB: _____ E-mail: _____

Address: _____

Emergency Contact Name and Phone #: _____

Referred by: _____

Reason for visit: _____

How long have you had this condition? _____ Is it getting worse? _____

What seemed to be the initial cause? _____

I have implanted electronic device **Yes | No**
I have a seizure disorder **Yes | No**
I am pregnant **Yes | No | N/A**
I have high blood pressure **Yes | No**
I have low blood pressure **Yes | No**
I have a history of lightheadedness, dizziness or fainting that has not been diagnosed by my PCP **Yes | No**
I have a PCP **Yes | No**
~ other wellness or alternative therapies you are participating in?

_____

List any other medical conditions and / or surgeries

_____

I have or have had cancer **Yes | No**
~ If yes, what was the diagnosis?

_____

~ If you are in remission, how long have you been in remission? _____

I am currently undergoing chemotherapy **Yes | No**
My chemotherapy treatments are scheduled to end

_____ **| N/A**

My last chemotherapy treatment ended

_____ **| N/A**

I have had surgery resulting in the placement of metal implants **Yes | No**
~ If yes where?

_____

PLEASE READ AND INITIAL THE FOLLOWING, AND SIGN BELOW:

_____ I understand that this PEMF therapy session is not a replacement for medical care, and that no diagnosis will be made.

_____ I understand that if I have a pacemaker, defibrillator, am pregnant or have any implanted device with a battery that cannot be removed, I do not qualify for PEMF sessions.

Signature: _____

Vital Waves

PEMF Therapy Session Consent Form

I, _____, hereby request a Pulsed Electro Magnetic Frequency (PEMF) therapy session. I understand that the PEMF devices used by Vital Waves create an adjustable pulsed electromagnetic field. PEMF therapy it is not intended to diagnose, treat, cure or prevent any medical condition. If concerned, users are encouraged to obtain the help, service and recommendations of licensed medical practitioners. PEMF devices used by Vital Waves are not medical devices and no claims are made that they can affect medical conditions. Each person responds to PEMF in their own unique way depending on age, lifestyle, general health, and may other factors.

Do not use PEMF devices if:

- You have an implanted electronical device including: pacemaker, defibrillator, cochlear hearing device, spinal stimulator, etc.
- You are pregnant
- You are actively bleeding, hemorrhaging, or during heavy menstruation

Before PEMF therapy session:

- Please hydrate before your session
- Please do not wear perfume, strong smelling deodorant, fragrances, essential oils, hand lotions, aftershave or cologne on the day of your visit
- Remove all electronic or battery-operated devices, cell phones, keys/fobs, wallets, ID and cards with magnetic strips such as credit cards etc., jewelry and hearing aids
- Vital Waves and their technicians are not responsible for damage to personal items that have not been removed prior to session

During PEMF therapy session:

- If you experience reactions that include but are not limited to nausea, headache, fatigue, or any uncomfortable sensations, we recommend suspending the session and consulting your doctor.

After PEMF therapy session:

- If you have been laying down, sit up slowly after a session as the body will be detoxifying and there is a chance of light headedness associated with this
- Thirst might be experienced after a session, continue to hydrate afterwards
- It is very common to feel the need to use the bathroom after a PEMF session

Payment due at time of service provided.

I have read and understand the above information and my rights and responsibilities and hereby consent to PEMF therapy.

_____ _____ _____

Signature (of Parent or Guardian if client is a minor) Name printed Date

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number _____

☐ Other _____
_____

_____ _____
Patient Signature Date

_____ _____
Print Name Birth Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
(2) Type key: T=Treatment Records; P=Payment Information; O=Healthcare Operations; A=Authorization on File; D=Discretionary
(3) Enter how disclosure was made; F=Fax; P=Phone; E=Email; M=Mail; O=Other

Vital Waves

Notice of Privacy Acknowledgement

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activates, public health, research, and law enforcement actives. Information will also be used to (1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, (2) Obtain payment from third party payers. (3) Conduct normal healthcare operations such as quality assessments and physical certifications. You may request restrictions on disclosures. Our practice has the right to accept or deny your request.

You may inspect and receive copies of your records within 30 days of a written request. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

You may request changes to your records, in writing. Our practice has the right to accept or deny your request.

In the future, we may contact you to provide appointments reminders or information about treatment alternatives, or other health-related benefits and services that may be of interest to you. Your Patient Record of Disclosure will be used to obtain contact. You have the right to request confidential communications by alternative means by resubmitting a Patient Record of Disclosure form.

Notice of care being provided in a "open-door" environment

It is the desire of this office to provide care in an "open-door" environment. An "open-door" approach involves doctors moving from one open area to another to perform patient care. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care. As a result, patients are occasionally within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and NOT the environment used for taking patient histories, performing examinations, or presenting reports or findings. These procedures are completed in a private, confidential setting.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

The effective date of this Notice of Privacy Practices is January 01, 2020

Signature: _____ Date: _____