Energetic Therapeutics

Angel Clark, M.S., L.Ac.
230 California Street, Suite 308
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415-710-4833
www.energetictherapeutics.com
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Welcome to Energetic Therapeutics.
If you are uncomfortable about filling in any part of this form, feel free to leave the space blank.

_____ _____
Name Date of Birth

_____ _____
Address Zip Code

_____ _____
Telephone (main) Telephone (alternate)

_____ _____
Email Occupation

_____ _____
Emergency Contact Phone

1. How did you hear about Energetic Therapeutics? _____

2. What do you hope to get out of our work together? _____

_____

3. Do you have any spiritual beliefs that you wish me to know about? _____

_____

4. Do you have questions about Energy Healings or Intuitive Readings?

_____

_____

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5. Have you worked with an energetic healer or intuitive reader before? _____

_____

6. If so, approximately when and in what form? _____

_____

7. In what ways, if any, did you benefit from your previous healing/reading? _____

_____

8. What were the least beneficial aspects? _____

_____

Life Goals

If your life reflected your heart's desire, what would your life be like?

_____

_____

_____

_____

_____

_____

_____

_____

_____

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How close do you believe you are to your Life Path?_____

_____

If applicable, what do you believe is between you and your Life Path? _____

_____

_____

Is there anything else you'd like to tell me?_____

_____

Medical History

1. Please check off any of the following conditions or symptoms that apply to you now and in the recent past.

___Abuse
___Addictions (please list_____)
___Allergies
___Anxiety
___Arthritis
___Auto-Immune Disorders
___Back Pain (Lower/Upper)
___Body Pain (please list where_____)
___Bruises Easily
___Cancer
___Contagious Conditions
___Depression
___Diabetes
___Difficulty in Breathing/Taking Deep Breath
___Fatigue
___Grief/Loss
___Headaches
___Heart Palpitations
___Heart Attack/Stroke
___High or Low Blood Pressure
___High Stress
___Hypoglycemia/Hyperglycemia
___Insomnia
___Low Libido
___Low Energy
___Night Sweats
___Osteoporosis
___Poor Concentration
___PMS/ Menstrual Irregularities
___Pregnancy
___Prostate Disorders
___Recent Weight Gain or Loss
___Skin Rashes
___Varicose Veins/Spider Veins
___Vertigo/Dizziness
___Violent Temper

2. Are you under the care of a medical physician? _____ If so, for what conditions?

_____

3. Have you ever received or currently receiving counseling or psychotherapy? _____

4. Have you had any serious chronic illnesses, operations or traumatic accidents or events?

_____

5. Please list any medications, herbal formulas, vitamins, or supplements taken consistently in the last two months. _____

6. Have you taken psychoactive drugs (prescribed or non-prescribed) in the present or past (ex. Prozac, LSD)?_____

7. Please list any diagnosis in the past and present in regards to a therapist/psychologist:

_____

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I, _____, understand that Angel Clark, when administering Energy Healing Treatments or Intuitive Readings, does not diagnose illness, disease or mental disorder. Nor does she prescribe medical treatment or pharmaceuticals. It has been made clear that the energy healing or intuitive reading is not a substitute for medical examination or diagnosis and that it is recommended that I see a Medical Doctor for any physical or mental ailment. Angel Clark's intention in providing intuitive information is purely informational and not for medicinal or curative purposes and I take it as such. Her intuitive recommendations are not intended to prevent, diagnose, mitigate or cure any illness or disease, or any emotional and or mental problems or personal problems. I have stated all of my known medical conditions and vow to keep Angel Clark updated on my physical, mental and emotional health. I am advised to disregard any intuitive information or suggestions that Angel Clark suggests that do not resonate with my personal choices, my intuition or my soul and to consult with an M.D. and legal advisor before participating in any of her intuitive suggestions. With this in mind, I agree that Angel Clark cannot be held liable for any problems that might arise that I think could be attributed to the energy healing or intuitive reading session. I attest that I understand the nature of the treatment and freely elect to receive treatments. I agree to hold Angel Clark free and harmless from any liability, demands, claims, suits for damages for any injury of complications whatever, save negligence, that may result from such recommendations and or energy healing or intuitive readings and from any adverse reaction I may have to the energy healing or intuitive reading, or to any intuitive recommendation.

I am of sound mind, and not under any mind altering drugs. By signing this agreement, I acknowledge that I have read the above, have thoroughly reviewed and understand its contents, and that I am giving my informed consent and agree to it.

Signature: _____Date:_____

24 HOUR CANCELLATION POLICY

I understand this office requires a 24-hour cancellation notice for appointments. Cancelling appointments within 24-hours or missing an appointment (except for valid emergency situations) will result in a charge of up to 100% of the normal fee for service. I understand and agree to uphold this cancellation policy.

Signature: _____Date:_____

Printed Name: _____Date:_____

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Patient Consent for Use and Disclosure of Protected Health Information (PHI)

With my consent, Energetic Therapeutics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

With my consent, Energetic Therapeutics may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist Energetic Therapeutics in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Energetic Therapeutics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient's statements as long as they are marked personal and confidential.

With my consent, to Energetic Therapeutics may email me appointment reminders and patient's statements. I have the right to request that Energetic Therapeutics restrict how it uses or disclosed my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bounded by this agreement.

By signing this form, I am consenting to Energetic Therapeutics use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Energetic Therapeutics may decline to provide treatment to me.
Signature of Patient or Legal Guardian:

Signature: _____Date:_____

Printed Name: _____ Date:_____

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Arbitration Agreement & Informed Consent

PATIENT NAME:

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California Law,and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement binds all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to call claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence-giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to allparties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within the thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon writ ten request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for noneconomic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statue of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provide wi thin 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here . Effective as the date of first professional services. If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL. SEE ARTICLE 1 OF THISCONTRACT.

PATIENT SIGNATURE _____DATE:_____

OFFICE SIGNATURE_____DATE:_____