HEALING OAK ACUPUNCTURE CLINIC

Acupuncture, Chinese Herbal & Holistic Medicine
Randall Wegener, L. Ac., Dipl. Ac., MSTOM, HAPM

LIFE COACHING INTAKE

PERSONAL INFORMATION

Date ______________________________

Patient's Name ____

Patient's Home Address

____

City ____ State ______ Zip _________________

Home Phone ___________________________ Work Phone __________________________________

Cell Phone ____________________________ Email ______________________________________

Social Security No. _______________________ Driver's License No. ____________________________

Occupation____

Employer____

Business Address ____

Name of Significant Other ____

Employer ____ Work Phone ________________________

Emergency Contact ________________________________ Phone No. _________________________

Person Responsible for Payment (If other than Patient)

Name ____

Mailing Address ____

City ____ State _____ Zip ____________

Home Phone __________________________ Work Phone __________________________________

Referred By/How did you hear about this clinic?

____

Have you received life coaching before? ☐ Yes ☐ No

When __________________ With whom ____

Sex: ☐ Male ☐ Female Height ____ Weight ____ Birth date _____ Age ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Engaged ☐ Partnered Number of children ____

Children's Name/Age

____

____

____

____

What are the main goals for which you are seeking coaching? (List in order of priority)

How long have you had this condition? ____________________

How does it affect your quality of life? ____________________

What is the best way for me to coach you most effectively?

Do you have any apprehension or preconceived ideas of coaching?

What are the main business/lifestyle changes you would like to achieve?

What is your vision/perception of your life?

What are your greatest achievements of your life?

What have been your greatest obstacles of your life?

What are your top 3 goals to accomplish in the next 3 months?

What are your top 3 obstacles?

What are your hobbies/What do you do for fun?

What pets do you have?

593 E. Elder Street, Suite A, Fallbrook, CA 92028
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How do you feel about the following areas of your life?
Please check the appropriate boxes and indicate any concerns you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Significant Other	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Diet	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	
Stress	☐	☐	☐	☐	☐	
Finances	☐	☐	☐	☐	☐	

Please indicate the use and frequency of the following:

	Yes	No	How Much		Yes	No	How. Much
Coffee/Black tea	☐	☐		Tobacco	☐	☐	
Non-medical drugs	☐	☐		Alcohol	☐	☐	
Water intake	☐	☐		Soda pop	☐	☐	

List any medications and supplements you are currently taking: (Continue on back of page if necessary)

Medicine	Dosage	Reason	How long	Prescribed by	Date of last Checkup

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I, ____, have read, reviewed, understand and agree to the Notice of Privacy Policies for Life Coaching services in this clinic.

This clinic has attempted to provide each patient with a copy of the Notice of Privacy Policies.

Patients name (Please print) ____

Patients Signature ____

Date _________________________

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NOTICE OF PRIVACY POLICIES

Our clinic is dedicated to providing healthcare service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

We gather personal information and health information in several ways:

Information we receive from you.
Information we receive from other health care providers.
Information we receive from third party payers.

This information is used for treatment, payment and healthcare operations.
You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment and healthcare operations.
You may specifically authorize us to use protected health information for any purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your protected health information.

Marketing

This clinic will not use your health information for marketing communications without your written authorization.

This clinic may send birthday cards newsletters and appointment reminder, by calls, postcards or letters.
Please circle one of the following: **Yes** **No**

Disclosure

This clinic may use or disclose your Protected Health Information when required by law.

Patients Rights

1. Upon written request you have the right to access, review or receive copies of your health records.
2. Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your Protected Health Information.
4. You have the right to request that we amend your Protected Health Information; the request must be in writing.
5. You have the right to receive all notices in writing.

If you have questions, complaints or want more information contact this clinic:

Healing Oak Acupuncture Clinic/Randall Wegener, L. Ac.
593 E. Elder Street, Suite A, Fallbrook, CA 92028
760-451-2188 / healingoakacupuncture.com

You can send a written complaint to:

U.S. Department of Heath and Human Services (DHHS Office of Civil Rights)

200 Independence Ave. S.W. Room 509 F HHH Building
Washington, DC 20201

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FEES, SERVICE AND PAYMENT AGREEMENT FOR LIFE COACHING

TO ALL NEW PATIENTS:

Welcome to our clinic. We hope that you find our clinic and staff pleasant.

CANCELING OR CHANGING APPOINTMENTS:

We will set a specific course of treatment for you. A certain number of treatments in a set amount of time may be required to get the desired results. If you need to change or cancel an appointment, be sure to make up the missed appointment as soon as possible. If for some reason you need to cancel your appointment please call ahead and let us know so that we may accommodate another patient at that time. **A no show, or without cancellation notice 24 hours minimum prior to the scheduled appointment, well result in a clinic visit charge for the visit.**

UPSETS:

We are here to serve you. Please feel free to speak with our office manager about any upsetting matter.

FEES:

The fees charged at this clinic are comparable to those charged by other specialists with similar qualifications in this geographic area. The fees for coaching sessions are payable ***at the time of the visit***, except in certain cases where arrangements have been made with our clinic. In those cases where payment arrangements have been made with our office and/or if your account becomes past due, we reserve the right to access financial charges at an interest rate of 1.5% of outstanding balance per month for every month that an account remains past due, after 30 days.

Life Coaching Session (Price based on one on one session)
Life Coaching can be preformed in person, over phone or on internet.
(A $25 deposit is required upon scheduling)

30 minute	$$40-$50
60 minute	$80-$100
90 minute	$120-$150
Extra time 15 minute intervals	$25
Extra person per session	$25

______________________________ _____________
Patient's Signature Date

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LIFE COACH DISCLAIMER OF LIABLITY

The Client hereby employs, Randall Wegener as Life Coach for the purpose of supporting the Client with respect to the Client's self-awareness, vision and goals, and strategic plans, has experience in such matters and agrees to render such coaching services. Client understands and agrees that Randall Wegener is not acting as a therapist providing psychological counseling, psychoanalysis or behavior therapy. Life coaching services may be performed in person, over the phone, or on the internet.

I, ____, have read, reviewed, understand and agree to the Life Coach Disclaimer of Liability for Life Coaching services in this clinic or in person at another location, on the phone or over internet.

Patients name (Please print) ______________________________

Patients Signature ______________________________

Date ____________________

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