Soul Alignment Healing

Brianna Anderson, RMT, CEP, LMT

Client Name: _____ Date: _____
Address:_____
_____
Phone: _____ E-mail: _____
DOB: _____ Age: _____ Occupation: _____
Emergency Contact: _____ Phone: _____
Spiritual Orientation: _____ Referred by: _____

What brings you in today? What are you hoping to experience or accomplish with Soul Alignment Healing?

_____
_____
_____

Family of Origin

Please draw the members in your family, including yourself, label who they are with a name and age. You can draw them as stick figures, shapes or symbols, or a family tree, whatever feels right for you.

FAMILY HISTORY AND QUESTIONNAIRE

Patient Name_____ Age_____ Gender_____

1. **CURRENT SYMPTOMS** Please circle any of the following that you are experiencing:

☐Poor sleep	☐Personality changes	☐Physical complaints	☐Racing heart
☐Poor appetite	☐Constipation	☐Feelings of inferiority	☐Suicidal feelings
☐Increased appetite	☐Diarrhea	☐Hearing voices	☐Blurred vision
☐Weakness	☐Weight loss	☐Seeing things	☐Shaky inside
☐Decreased sex drive	☐Tiring easily	☐Paranoia	☐Avoiding people
☐Hyperventilation	☐Abdominal discomfort	☐Anger	☐Inability to have fun
☐Palpitations	☐Feelings of hopelessness	☐Fearfulness	☐Short-tempered
☐Depression	☐Lack of interest	☐Phobias	☐Worrying a lot
☐Nausea	☐Anxiety	☐Low self-esteem	☐Inability to relax
☐Headaches	☐Feelings of guilt	☐Socially withdrawn	☐Menstrual changes
☐Crying easily	☐Family problems	☐Dry mouth	☐Numbness
☐Indecisiveness	☐Poor attention span	☐Nightmares	☐Sexual problems
☐Work problems	☐Ringing in ears	☐Dizziness	☐Shaky hands
☐Irritability	☐Other	☐Other	☐Other

A. Mention any other significant and/or unusual habits (include history of smoking, alcohol and drug use)

_____

B. When did you last feel well? _____

2. **CURRENT STRESSORS**

A. Have you been having any interpersonal distress in the past 12 months? No☐ Yes☐ Explain:_____

_____

B. Have you been injured, stressed, or exposed to toxic chemicals at work during the past 12 months? No☐ Yes☐ Explain _____

3. **PAST MEDICAL HISTORY**

A. Hospitalizations (Physical Illness)
When_____Where_____Illness_____

B. Hospitalizations: (Non Physical illness)
When_____Where_____Illness_____

C. Outpatient Psychological Treatment
When _____Where_____With Whom_____

4. **CURRENT MEDICAL HISTORY**

A. Do you have any current medical problems? No☐ Yes☐ Explain:_____

B. Do you take any medications? List._____

C. Do you experience side effects from these medications? List_____

D. Do you have allergies? List._____

E. Have you had trouble with any of the following, yes or no?

Glaucoma No☐ Yes☐ Blood Pressure No☐ Yes☐ Kidney No☐ Yes☐ Asthma No☐ Yes☐
Prostate No☐ Yes☐ Heart No☐ Yes☐ Diabetes No☐ Yes☐ Liver No☐ Yes☐
Other ☐ If yes for any, explain_____

F. What is the name of your family doctor, or other doctors you have seen in the past year?

Name:_____Address _____Phone#_(____)_____
Name:_____Address _____Phone#_(____)_____

5. **FAMILY HISTORY**

A. MOTHER'S Maiden Name:_____ Age_____ If deceased, cause & age_____
Occupation:_____ Current state of health:_____
Nervous/emotional problems?: No☐ Yes☐ Hospitalized?: No☐ Yes☐ Explain_____

_____

B. FATHER'S Name:_____ _____ Age_____ If deceased, caus age_____
Occupation:_____ Current state of health:_____
Nervous emotional problems? No☐ Yes☐ Hospitalized? No☐ Yes☐ Explain_____
_____

C. Raised by: Parents☐ Step-parents☐ Grandparents☐ Foster parents☐ Foster Home☐ Other☐
D. Siblings: Brothers Name(s) & Age(s) :_____
Sisters Name(s) & Age(s) _____
E. Goals and Ambitions: as a child_____
as an adult :_____

6. SEXUAL ADJUSTMENT
A. Sexual Education Yes☐ No☐ By Whom? School☐ Father☐ Mother☐ Books☐ Friends☐
B. Significant and or unusual sexual experiences _____
C. Do you have any sexual problems? Explain_____

7. MARITAL HISTORY
1st Marriage: Age ____Spouse's Age ____Duration_____If ended, reason_____
Relationship with spouse _____
Children: No☐ Yes☐ How many and ages: _____
2nd Marriage: Age ____Spouse's Age ____Duration_____If ended, reason_____
Relationship with spouse _____
Children: No☐ Yes☐ How many and ages: _____
Other significant relationships_____

8. EMPLOYMENT HISTORY
Currently employed? No☐ Yes☐ How long?_____Salary_____Title_____
Is this your usual job? No☐ Yes☐ Longest ever held a job _____Shortest time_____
Reason for changing jobs:(if different jobs specify which) _____
Fired☐ Resigned to get better job☐ Did not get along with the boss/co-workers☐

9. MILITARY (The following questions are only for people with military experience.)
Your total time (years) in Service _____ Highest rank _____ Branch _____
Honorable discharge Yes☐ No☐ Reason if No_____

10. HABITS
Drink (Alcoholic Beverages) No☐ Yes☐ Socially☐ Rarely☐ Frequently☐ Daily☐ Weekends☐
During Day☐ At work☐ Other _____ Approximate amount_____
Age started drinking _____ Do you or anyone else think that your drinking is a problem? No☐ Yes☐
Have you ever used street drugs? No☐ Yes☐ What/When_____
Are you currently using/abusing any non-prescription drugs? No☐ Yes☐ What/When_____

1. CONFLICTS WITH THE LAW
No☐ Yes☐ As: Child☐ Teenager☐ Adult☐ Describe_____

2. EDUCATION
Highest school grade completed _____ Grades repeated or Dropout?_____Reason_____
Missed classes? No☐ Occasionally☐ Frequently☐ Reason_____ Like school? Yes☐ No☐
Favorite subject(s)_____ Grades: Average☐ Above Average☐ Below Average☐
Relationships with teachers: Liked☐ Disliked☐ Got Along☐ Didn't get along☐
Relationships with classmates: Mixed☐ Withdrawn☐ Fights☐ Many friends☐ Few Friends☐

_____ _____ _____
Signature of person providing information Relationship to Patient Date

Soul Alignment Healing

Brianna Anderson, LMT

Informed Consent

I, _____ (client) understand that treatments provided by Brianna Anderson are composed of a combination of therapeutic modalities which include: soul memory discovery, energy work, Reiki, hypnotherapy, massage, crystal healing and flower essences. The general benefits of each of the therapeutic modalities and their treatment procedure as well as any possible contraindications have been explained to me. I am aware that the combination of therapeutic modalities that Brianna uses are based upon principles that harmonize and balance the energetic state and condition a client is experiencing. I also understand that I have the right to pick and choose which therapeutic modalities I am interested in, and that I have the right to decline any forms of treatment.

Further, I also understand that Brianna Anderson is not a medical practitioner, nor does she diagnose illness or disease. I am aware that she cannot make absolute guarantees concerning the elimination of my particular challenge. I also understand that these treatments are not a substitute for medical treatment, medications or psychotherapy, and that it is recommended that I concurrently work with my primary caregiver for any condition I may have.

I have informed Brianna of all my known physical, emotional, mental and spiritual concerns and conditions, as well as any medications I am taking or any limitations I may have. I agree to keep Brianna updated on any changes.

I am also aware of Brianna's cancelation policy. Which is a 24 hour policy. If cancelation or rescheduling is not done 24 hours prior to the scheduled appointment the full fee for the treatment will be owed before any further treatment sessions can take place.

If you choose to cancel or reschedule your appointment with a text message you may do so. However, sometimes text messages do not go through. If I do not respond to your text message it is because I did not receive it – cancelation and rescheduling may best be done through email and phone calls. If I have no record of your text message, then it does not count towards the 24 hour cancelation policy.

I am also aware of Brianna's bounced check policy. Which is an additional $25.00 fee for the bounced check, plus the amount owed.

I am also aware that Brianna's fee is based on time spent with her. I am aware that if the session goes over or lasts longer than the allotted time I will be charged accordingly.

I _____, (client) understand the above statement and have received a copy of these policies. I understand them and agree to abide by them.

Client's signature _____ Date_____

Client's name printed _____

Brianna Anderson _____ Date _____

Office Policies

Payment for Services: Patients are expected to pay for services at the time services are rendered. This office only bills insurance claims for those patients with whose insurance companies we have contracts. You will be informed if this is the case with your insurance. All other patients are expected to file their own insurance claim forms. Patients are reminded that professional services are rendered to the patient, not to the insurance company. The patient is ultimately responsible for the payment of services rendered. Please inform the office immediately if your insurance changes, as failure to do so will result in charges billed directly to the patient.

Fee for Services include, but are not limited to, $ ____ for sixty minute individual sessions, $ _____ for conjoin or family sessions, and $___ for group therapy. Telephone consultations are billed at $25 for fifteen-minute increments. The fee for completion of brief forms is $25. Narrative reports are billed at $100 per page. There is a $25 fee for returned checks. All fees are subject to change. Some services, such as telephone consultations and narrative reports, are not typically covered by insurance companies and will be billed directly to the patient.

Cancellation of Appointments: A scheduled appointment is a reservation of time for the patient. Therefore**, a minimum of twenty-four (24) hours' notice is required to cancel an appointment.** Patients who fail to give twenty four hour notice will be charged their regular fee for the appointment. **Insurance does not reimburse for late cancellations or no shows**. There are no exceptions to the twenty four-hour cancellation policy. Our office does not call patients to remind them of scheduled appointments.

Emergency Procedures: To contact your therapist call (949) 370-2633, and leave a message if the phone is not answered. Messages are checked several times per day, and all phone calls are returned in a 48-hour period of time. In the case of a life threatening emergency that requires immediate assistance dial 911.

Confidentiality: Information discussed during therapy sessions is considered confidential and will not be revealed without written authorization except as permitted by law. In certain circumstances, therapists are required by law to report suspicious of child abuse, elder abuse, and dependent adult abuse. Further, disclosure may be necessary if a patient presents a danger to himself or others, or where the patient is gravely disabled. Disclosure may also be pursuant to a legal proceeding.

Treatment: The majority of individuals benefit from the therapy process, but results vary dependent on the conditions being treated. It is possible that a patient will not improve. There is a potential for disruption in your life while in treatment, and therapy can be emotionally painful. Your initial evaluation will include an explanation of your diagnosis, treatment plan, and length of treatment.

I hereby authorize Soul Alignment Healing Services to release any and all information regarding my psychological, drug or alcohol treatment to my insurance carrier and/or medical group for the purpose of claims administration and evaluation, utilization review and financial audit. I hereby assign Brianna Anderson all obtainable monies for services rendered. I understand that any money received from any responsible party over my indebtedness will be refunded to me when my bill is paid in full. I also understand that I am responsible for charges not covered by my insurance assignment. I further agree in the event of non-payment, to bear the cost of my indebtedness along with any cost of collection, and/or court cost and reasonable legal fees should this be required.

I Have Read and Understand These Office Policies

Patient Name:_____ Date: _____

Signature of patient, parent, legal guardian, or legal representative:

_____

3551 Camino Mira Costa # K, San Clemente CA 92672 Phone (949) 370-2633

Soul Alignment Healing

Brianna Anderson, LMT

Notice of Privacy Practices – Brief Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy

My practice is dedicated to maintain the privacy of your personal health information as part of providing professional care. I also am required by law to keep your information private. These laws are complicated, but I must give you this important information. However, I can't cover all possible situations so please talk to me about any questions or problems.

I will use the information about your health which I get from you or others mainly to provide you with treatment, to arrange payment, for my services, and for some other business activities which are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let me use and share your information. **If you do not sign this form, I cannot treat you.**

If I or you want to use or disclose (send, share, release) your information for any other purpose I will discuss this with you and ask you to sign an Authorization Form to allow this.

Of course I will keep your health information private but there are some times when the law requires me to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization which is able to help prevent or reduce threat.
2. Some lawsuits and legal or court proceedings
3. If a law enforcement official requires to do so.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place which is more private for you. For example, you can ask me to call you at home and not at work to schedule or cancel an appointment. I will try my best to do as you ask.
2. You have the right to ask me to limit what I tell people involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information I have about you such as your spiritual/psychological records. You can even get a copy of these records but I may charge you.
4. You have the right to a copy of this notice.

If you have any questions regarding this notice or my health information privacy policies, please speak with me.

Soul Alignment Healing

Brianna Anderson, LMT

Consent to Use and Disclose your Health Information

This form is an agreement between you, _____ and Brianna Anderson, LMT. When we use the word "you" below, it can mean you, your child, a relative or other person if you have written his or her name here _____.

When I examine, test, diagnose, treat, or refer you I will be collecting what the law calls Protected Healthcare Information (PHI) about you. I need to use this information here to decide on what treatment is best for you and to provide any treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment of for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others. The notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future I may change how we use and share your information and so may change my Notice of Privacy Practices. If so, you will be informed of the changes and given a copy.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if I do agree, I promise to do as you asked.

After you have signed this consent, you have the right to revoke it (in writing) and I will comply with your wishes about using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____

Signature of Client or his/her personal representative **Date**

_____ _____

Printed name of client or personal respective **Relationship to the client**

_____

Signature of authorized representative of this office or practice

Credit Card Authorization Form

For Brianna Anderson

I hereby authorize Brianna Anderson to charge my credit card for unpaid fees, therapy sessions, fees for late cancellations or no show appointment as per the signed office policy agreement. I will be notified for any fees charged at the time of the transaction.

Legal Name:_____

Name on the Credit Card:_____

Billing Adress:_____

City:_____ State:_____ Zip Code:_____

Telephone Number: (_____)_____ Cell: (_____)_____

Mastercard_____ Visa_____

Credit Card Number:_____

Expiration Date:_____ /_____

Month Year

CVV Number (3 Numbers on the back): _____

Cardholders Signature:_____