Lemon Grove
Yoga and Massage

It is our belief that we all have the light within us which allows us to love and heal ourselves, others and the earth.
We can provide you with guidance, practices and sacred space for your journey into your inner light.

PERSONAL INFORMATION

This is a confidential questionnaire to help us determine the best treatment plan for you. If you have any questions, please ask. Thank you.

Name _____ Date _____

Home Address _____ Apt/Suite _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

How do you want us to contact you? (check all that apply, appointment confirmations only): ☐ Text ☐ Email ☐ Phone Call

Emergency Contact Name _____ Phone _____

How did you hear about us? _____

Gender ☐ Male ☐ Female ☐ Trans MTF/FTM (circle one) Birthdate _____ Age _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partnered Number of children _____

Which of the following treatments have you received in the past (please check all that apply)?

☐ Massage ☐ Reiki ☐ Breathwork ☐ Acupuncture ☐ Neurolinguistic Coaching ☐ Nutritional Counseling

Please list any specific conditions for which you received the treatments above

Please indicate your health history as relates to the following. If it occurred more than once, please use notes below:

Type	Which area of the body?	Approx. Date	Outcome	Any current medications?	If yes, please list names.
☐ Surgeries				☐	
☐ Car Accident				☐	
☐ Sports Injuries				☐	
☐ Psychiatric Diagnosis				☐	
☐ Infectious Diseases				☐	

Notes

List any medications and supplements you are currently taking (Continue on a separate page, if necessary)

Medication	Dosage	Reason	How Long	Prescribed By	Date of Last Checkup

Check the box if any of the following statements are true

☐ I have known allergies ☐ I am taking Coumadin/Warfarin ☐ I have a Pacemaker ☐ I am taking Lithium

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Please indicate any significant illnesses you or a blood relative (Grandparent, parent or sibling) have had

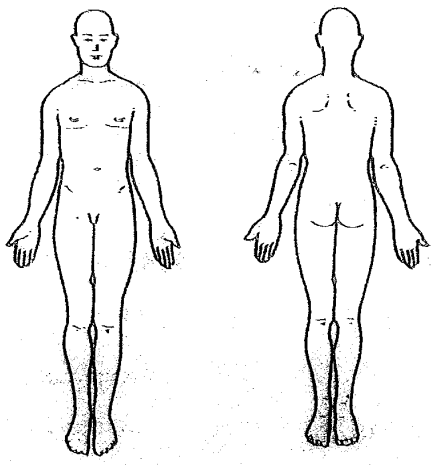
Illness	You	Your Relative	Approx. Date	Illness	You	Your Relative	Approx. Date
Cancer	☐	☐		Diabetes	☐	☐	
Hepatitis	☐	☐		Heart Disease	☐	☐	
High Blood Pressure	☐	☐		Seizures	☐	☐	
Rheumatic Fever	☐	☐		Emotional Disorders	☐	☐	
Infectious Diseases	☐	☐		Tuberculosis	☐	☐	

Sexually Transmitted Diseases: ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ HPV ☐ Chlamydia ☐ Herpes Date _____

Please indicate the use and frequency of the following

	Yes	No	How Much		Yes	No	How Much		Yes	No	How Much
Coffee/Black Tea	☐	☐		Tobacco	☐	☐		Water Intake	☐	☐	
Non-medical Drugs	☐	☐		Alcohol	☐	☐		Soda Pop	☐	☐	

MASSAGE CLIENTS ONLY



Please circle areas on which you need most work done today, then answer the following question regarding the indicated areas:

1. Please describe the pain (Check all that apply):

☐ Sharp ☐ Dull/Ache ☐ Soreness ☐ Local ☐ Radiating (moves to other areas)

On the scale of 1 to 10 (10 being extreme pain), rate your pain at its worst _____

2. How long have you had this sensation? _____
3. What aggravates the pain? _____
4. What alleviates the pain? _____
5. What kind of pressure would you like on this area?

☐ Light ☐ Medium ☐ Heavy ☐ Deep Tissue ☐ Stretching/Traction

When was your last massage? _____ Type of massage: _____

What was your response to your last massage? _____

Please list any areas of sensitivity that should be avoided during the session (i.e. wounds, varicose veins, etc.)

_____

I certify that I received a copy of the Lemon Grove Yoga and Massage privacy practices. I also certify that all information I provided on this intake sheet is true, and that I am physically capable of receiving this treatment. I also will alert the therapist of my physical preferences during the course of the treatment.

_____ _____ _____

Print Name Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information.

Please review it carefully.

The terms of this Notice of Privacy Practices apply to Breakthrough Healing Arts, with San Diego locations in Pacific Beach and Carlsbad, practitioners and other licensed professionals seeing and servicing clients at each location. A complete listing of our service locations is available upon request. The members of this clinically integrated health care arrangement work and practice at some or all of the service locations. The members of this clinically integrated health care arrangement will share personal health information of clients as necessary to carry out treatment, receive payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our clients' personal health information and to provide clients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of the Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices at any service location or a copy may be obtained on the web at www.breakthroughealing.org or by mailing a request to our mailing address.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization: Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There will be certain uses and disclosures of your personal health information for which we will always obtain a prior authorization and these include:

Marketing Communications: Unless the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment.

Most Sales of your personal health information unless for treatment or payment purposes or as required by law.

Life Coaching Notes: Unless otherwise permitted or required by law.

Uses and Disclosures for Treatment: We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, test, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if after you leave the facility, you are going to receive home health care, we may release your personal health information to that home health care agency so that a plan of care can be prepared for you.

Uses and Disclosures for Payment: We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our clients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a client relationship with you.

Family and Friends Involved In Your Care: With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individual's without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising: We may contact you to donate to a fundraising effort for or on our behalf. You have the right to "opt-out" of receiving fundraising materials/communications and may do so by sending your name and address to our mailing address together with a statement that you do not wish to receive fundraising materials or communications from us.

Appointments and Services: We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. You may request such confidential communications in writing and may send your request to our mailing address.

Health Products and Services: We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a researcher may wish to compare outcomes of all clients that received a particular drug and will need to review a series of medical records. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or Privacy Board which oversees the research or by representations of the researchers that limit their use and disclosure of client information.

Confidentiality of Alcohol and Drug Abuse Client Records: The confidentiality of alcohol and drug abuse client records maintained by this facility is protected by federal law and regulations. Generally, the facility may not say to a person outside the program that you attend a drug or alcohol program, or disclose any information identifying you as an alcohol or drug abuser unless: (1) you consent in writing: (2) the disclosure is allowed by a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Federal law and regulations do not protect any information about a crime committed by you either at our facility or against any person who works for the facility or about any threat to commit such a crime. Federal laws and regulations do not protect any

information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Other Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your personal health information without your authorization. We may release your personal health information as follows:

- For any purpose required by law; including suspected child abuse or neglect; or if we believe you to be a victim of abuse, neglect, or domestic violence; if required to do so by a court or administrative ordered subpoena or discovery request; if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings; as required by law to report wounds, injuries, and crimes;
- For public health activities, such as required reporting of disease, injury, birth, death, and for required public health investigations; or if in limited instances if we suspect a serious threat to health or safety;
- To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care to you at the request of your employer to determine workplace related illness or injury;
- To coroners and/or funeral directors consistent with the law;
- If necessary to arrange an organ or tissue donation from you to a transplant recipient for you;
- If you are a member of the military as required by armed force services; we may also release your personal health information if necessary for national security or intelligence activities; and
- To workers' compensation agencies if necessary for your workers' compensation benefit determination.

Ohio Law: Ohio law requires that we obtain an authorization from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition; before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program; before disclosing information about mental health services you may have received; and before disclosing certain information to the State Long-Term Care Ombudsman. For full information on when such authorizations may be necessary, you may contact us at our mailing address or by phone.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information: You have the right to obtain a copy and/or inspect much of the personal health information that we retain on your behalf. You have a right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to the entity or person designated by you provided that any such delegation is clear, conspicuous, and specific with complete name and mailing address or other identifying information. All requests for access must be made in writing and signed by you or your representative.

Amendments to Your Personal Health Information: You have the right to request in writing that personal health information we maintain about you be amended. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction requests.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of disclosures made by us of your personal health information up to six years prior to the date of your request. Requests must be made in writing and signed by you or your representative. You may be charged a fee if you request more than one accounting within the same 12-month period. All requests for an accounting must be made in writing and signed by you or your representative.

When you request an accounting of disclosures of your electronic health record, the accounting will be for three years prior to the date of the request for the accounting and will include, in addition to all types of disclosures listed in the general policy, disclosures for treatment, payment, and health care operations. These

requirements apply to those disclosures made by Breakthrough Healing Arts from such a record on or after the later of January 1, 2011 or the date that an electronic health record is acquired.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request in writing, restrictions on certain Breakthrough Healing Arts uses and disclosures of your personal health information for treatment, payment, or health care operations. A restriction request form can be obtained from us by phone, email or mail. Breakthrough Healing Arts is not required to agree to your restriction request except when the restriction request pertains to a disclosure to a health plan for purposes of carrying out payment or health care operations when the information pertains solely to a health care service for which we have been paid in full by you. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice by mail to Breakthrough Healing Arts.

Breach Notification: In the unlikely event that there is a breach, or unauthorized release of your personal health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints: If you believe your privacy rights have been violated, you may file a complaint to us in writing. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at Office for Civil Rights, U. S. Department of Health and Human Services, 233 N. Michigan Ave., Suite 240, Chicago, IL 60601, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgement of Receipt of Notice: You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices.

FOR FURTHER INFORMATION AND REQUESTS

If you have questions or need further assistance regarding this Notice, or wish to exercise any of the rights stated in this Notice, you may contact Breakthrough Healing Arts in writing at 4330 Cass Street, San Diego CA 92109 or by phone at (619)786-3033.
As a client you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

The Notice of Privacy Practices is effective August 17, 2009.