Rocheford's on the Pond

A Healing Center for the Body

11108 Zealand Ave N, Suite 107
Champlin, MN 55316

CLIENT CONSULTATION

Client: _____

Date: _____ Referred by: _____

Cell Phone: _____ Home Phone: _____ Work Phone:_____

E-Mail: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ _____Zip Code:_____

1. What is your health issue?

2. How long have you had it?

3. What are your symptoms and conditions?

4. Which one or two symptoms or conditions bother you the most right now? And why?

5. Has it been diagnosed by a doctor? ☐ No ☐Yes When? _____

6. Do you believe one or more events triggered your condition? ☐ No ☐Yes What? _____

_____

7. Is there anything else you'd like to tell me regarding your health?

CLIENT CONSULTATION

Client: _____

Date: _____

8. What treatments have you had for this health issue, symptoms and conditions?

☐ Acupuncture ☐ Aerobic Exercise ☐ Chiropractic ☐ Cognitive/Behavioral Therapy ☐ Craniosacral Therapy

☐ EEG-based Stimulation ☐ Massage ☐ Myofascial Release ☐ Nutritional Therapy ☐ Occupational Therapy

☐ Physical Therapy ☐ Postural Training ☐ Relaxation Therapy ☐ Trigger Point Injections

☐ Trigger Point Therapy ☐ Stretching (Yoga) ☐ Other _____

9. Are you currently taking drugs, herbs or supplements? ☐ No ☐Yes If yes, fill out page below

NAME	DOSAGE/FREQ.	DATE STARTED	REASON
PRESCRIPTION DRUGS			
OVER-THE-COUNTER DRUGS			
HERBAL / DIETARY SUPPLEMENTS			

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CLIENT BILL OF RIGHTS

I am pleased to provide you with this Client Bill of Rights, in accordance with Minnesota laws governing complementary and alternative health care practices.

1. Education – degrees, training, and experience:
   Practitioner Information: I have been doing energy healing all my *life and as* a *practice since* 2004. *For more information on Michael's background see* www.rochefordsonthepond.com

   In accordance with Minnesota law, I am providing you with the following notice:
   THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.

   Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.

2. Right to file a complaint. I am the supervisor of my private practice. If you have any concerns, you may file a complaint with me (see address above) and/or with the following office:

   Office of Unlicensed Complementary and Alternative Health Care Practice
   Health Occupations Program Minnesota Department of f Health
   Post Office Box 64882, St. Paul, MN 55164-0882
   651.201.3728 or by e-mail at health.hop@state.mn.us.

3. Fees, Payment, Insurance. Fees are based on the service provided. See appointment confirmation for your fee and payment options. The fee is payable in full before the session unless other arrangements have been made in advance. Payments may be made by *cash, check or credit card.* Make checks payable to Rocheford's on the Pond. We do not accept Medicare, Medical Assistance, or General Assistance Medical Care.

4. Cancellation Policy. If you must cancel a session, please cancel 24 hour prior to the start of the session. In case of an emergency, please call as soon as possible.

5. Change in services or charges. You have a right to reasonable notice of changes in services or charges, and I will provide prior notice of any changes.

6. Summary of Practices/Services. Please see http://www.rochefordsonthepond.com/Services

7. Information about assessment and recommended service. You have a right to complete and current information concerning my assessment and recommended service, including the expected duration of the service to be provided. If you have any questions, please ask.

8. Courteous treatment. You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by the practitioner.

9. Confidentiality of client information. Your records and other information about you are confidential. This information will not be released, unless you authorize release in writing, or unless release is required by law.

10. Access to client records. You are allowed access to records and other written information, in accordance with Minnesota Statutes, section 144.291 to 144.298.

11. Other available services. If you are interested in other available services in the community, you may wish to consult with Rocheford's on the Pond for other practitioners in your area.

12. Change practitioners. You have the right to choose freely among available practitioners and to change practitioners after services have begun, within the limits of health insurance, medical assistance, or other health programs.

13. Coordinated transfer. If you change practitioners, you have the right to our assistance in coordinating this transfer to another practitioner.

14. Refusing services. You have the right to refuse services or treatment, unless otherwise provided by law.

15. No retaliation. You may assert your rights without retaliation.

I _____ acknowledge, by my signature below, that I have received, understand and have had full opportunity to ask any questions on the Complementary and Alternative Health Care Client Bill of Rights and have consented to treatment.

I understand Alternative Energy Healing utilizes new energy techniques to allow for healing on the physical, emotional, and spiritual levels. These energies are initiated by your Alternative Energy Healing Practitioner at the start of your session and continue working long after your visit has ended. I acknowledge these sessions may involve respectful touch.

I release my practitioner from any liability for my physical condition and state of mind. I understand my energy field is unique and may respond in unique ways to energetic healing. I agree to take full responsibility for my self-care and personal development. I recognize there is a close working relationship between myself and my practitioner that requires me to share my ideas, perceptions, and opinions readily.

I understand my practitioner does not provide a medical diagnosis, recommend discontinuance of medically prescribed drugs, or act as your physician or therapist. I understand it is my responsibility to seek and maintain relationships with a licensed health care provider for traditional medical care. I agree that I am ultimately responsible for my health care. I knowingly, voluntarily and intelligently consent to use the services offered above. All my questions about these services have been answered to my satisfaction.

Except in the case of gross negligence or malpractice, I or my representative(s) agree to fully release and hold harmless *Michael D. Rocheford* from and against any and all claims or liability of whatsoever kind or nature arising out of or in connection with my session(s).

Signature: _____ Date: _____

Parent or Guardian Signature required for minors (Le., if client is under 18)