Daniels and Associates, LLC

Counseling - Coaching - Wellness

WELLNESS CLIENT INFORMATION—ADULT

Client Name: _____ Date of Birth: _____ M / F

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____

E-Mail: _____

Employment (circle): Full-time Part-time Not employed Student

Occupation_____ Employer/School_____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

Family Physician or Primary Care Provider: _____

How were you referred to us? _____

Health – PAR-Q Form

- Has your doctor ever said that you have a heart condition, and that you should only do physical activity recommended by a doctor? Yes/No
- Do you feel pain in your chest when you do physical activity? Yes/No
- In the past month have you had chest pain when you were not doing physical activity? Yes/No
- Do you lose your balance because of dizziness, or do you ever lose consciousness? Yes/No
- Do you have a bone, joint or any other health problem that causes you pain or limitations that must be addressed when developing an exercise program (I.e., diabetes, osteoporosis, high blood pressure, high cholesterol, arthritis, anemia, epilepsy, respiratory ailments, back problems, etc.)? Yes/No
- Are you pregnant now, or given birth within the last six months? Yes/No
- Have you had a recent surgery? Yes/No
- Do you take any medications (prescription or non-prescription) on a regular basis? Yes/No
    - What is the medication for? _____
- Do you know of any other reason why you should not do physical activity? Yes/No
- If you marked “yes” to any other the above, please explain:

Agreement and Release of Liability

- In consideration of being allow to participate in the actives of the wellness program of Daniels and Associates, LLC, and to use its facilities, equipment and machinery in addition to the payment of any agreed upon fee or charge, I do herby waive, release and forever discharge its directors, officers, agents employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery in the above mentioned activities. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities through Daniels and Associates, LLC.
- I understand and am aware that strength, flexibility and aerobic exercise including the use of equipment is a potentially hazardous activity. I also understand that fitness activities involved the risk of injury and even death and that I am voluntarily participating in these activities with knowledge of the dangers involved. I understand this program does not provide any form of medical treatment nor are its fitness professionals licensed medical practitioners. I hereby agree to expressly assume and accept any and all risks of injury or death.

Signature: _____ Date: _____

WELLNESS PRIVCY PRACTICES

The information provided in this intake form is not considered Personal Health Information (PHI) subject to HIPAA regulations. However, your wellness professional will make every reasonable effort to preserve the privacy of the information contained in this intake form, and will not disclose any personal information without the client's written consent. Daniels and Assoicates, LLC, its executors, administrators or assignees shall not be liable or responsible for any inadvertent disclosure of the information contained in this intake form.

WELLNESS FINANCIAL AGREEMENT

Fees for **Personal Training** and **Post Rehabilitation** are _____ per 50-minute session.

Payment is expected at the time of service unless other arrangements have been made.

Accepted method of payments include: cash, credit, debit, HSA card or personal check. Checks are to be made payable to **DANIELS AND ASSOCIATES, LLC**.

Health Insurance. **DANIELS AND ASSOCIATES, LLC** will not bill your insurance directly. If you would like to use health insurance benefits for wellness, we ask that you pay your fee upfront, then seek reimbursement through your health insurance plan. Your wellness professional will provide you with the necessary forms for you to seek reimbursement.

At least **24 hours-notice** is required for cancelation. If a scheduling emergency occurs, the client is to contact the counselor as soon as possible. If adequate notice is not provided, or the client is a "no show" for the scheduled appointment, the client will be billed the entire session amount for the missed appointment.

PRINTED: Client Name _____

CLIENT SIGNATATURE: _____. Date: _____