PEGGY DEMAIO, LMT
CHRONIC PAIN SPECIALIST

Peggy DeMaio LMT is committed to excellence in serving the health needs of the community. We are dedicated to giving each client a personal service that they can rely on & trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask, we will be happy to assist you.

Patient Information

Name: Last _____ *First* _____ *MI* _____ *Date* _____

Current Address: _____

City _____ *State* _____ *Zip* _____

Phone #: Home _____ *Work* _____ *Cell* _____

Email: _____

☐ *Male* ☐ *Female* ☐ *Non-Binary* *Date of Birth:* _____

Employer _____ *Occupation* _____

Employer address _____

City _____ *State* _____ *Zip* _____

Family Doctor _____

Who can I thank for this referral? _____

Cancellation / No Show Policy:
If you need to cancel your appointment, please call us ASAP so we can offer your appointment to another patient. If less than 24 hours' notice is given prior to your appointment time or if you do not show up, you will be charged for the treatment that you were scheduled for. Please keep in mind others may be seeking the time we have reserved for you. Thank you for your consideration!

Initial _____

Consent for Care and Treatment:
We will complete an evaluation process via interview and examination. From these findings, a treatment plan will then be designed, utilizing a variety of treatment techniques. I, the undersigned, do hereby agree and give consent for Peggy DeMaio LMT to provide treatment identified as proper and necessary in addressing my physical condition.

Initial _____

I agree that the information above is accurate. I understand the terms of this form and realize that I am financially responsible for charges incurred from cancellations or no shows.

Patient Name: _____ Date: _____

Patient Signature: _____

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Payment Policy

In striving to provide each individual with personalized service, Peggy DeMaio LMT accepts payments via cash, FSA credit accounts, Visa or MasterCard. We ask for full payment to be rendered at the time of service. * Some session times include a total of 10 minutes of time for consultation and dressing, which occurs pre and post treatment. The teaching of home exercise programs is included in the treatment time if your treatment plan includes home self-care.

Treatment Price List

*Prices effective 1/1/24

Customized Therapeutic Treatment Packages

30 Minutes	$145
60 Minutes	$200
90 Minutes	$275
Super 6 Pack Save $60	$1,140
*Our Most Popular:Deluxe Dozen Save $240	$2,160
HardcoreWellness Purchase 20 1-hour treatments SAVE $470 Usually for those who have had chronic issues for 1 year or more	$3,530

Packages are valid for 12 months starting with your first treatment of that package.

Referral Rewards Program

We APPRECIATE Your Referrals!

As a heartfelt "Thank You" for telling your friends, coworkers and family members about the unique personalized services offered by Peggy DeMaio LMT, we would like to offer YOU the following incentive program:

- $40 off your next 1-hour Treatment for each new client you refer.
- You will receive 1 free hour of treatment for every 8 new clients you refer.

E-Gift Cards Available for Purchase

https://squareup.com/gift/2HDAT1DHRVP42/order

Patient Name: _____ Date: _____

Patient Signature: _____

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Medical History

Do you:

Smoke	☐ Yes	☐ No	Years smoked: _____
			Packs per day: _____
Use artificial sweeteners:	☐ Yes	☐ No	
Drink diet soft drinks:	☐ Yes	☐ No	Drinks per day: _____
Usually sleep through the night:	☐ Yes	☐ No	
Sleep with a pillow between your knees:	☐ Yes	☐ No	
Take any statin drugs (cholesterol lowering):	☐ Yes	☐ No	

Current medications: _____

_____

Allergies to: drugs, food or other items (including latex): _____

_____

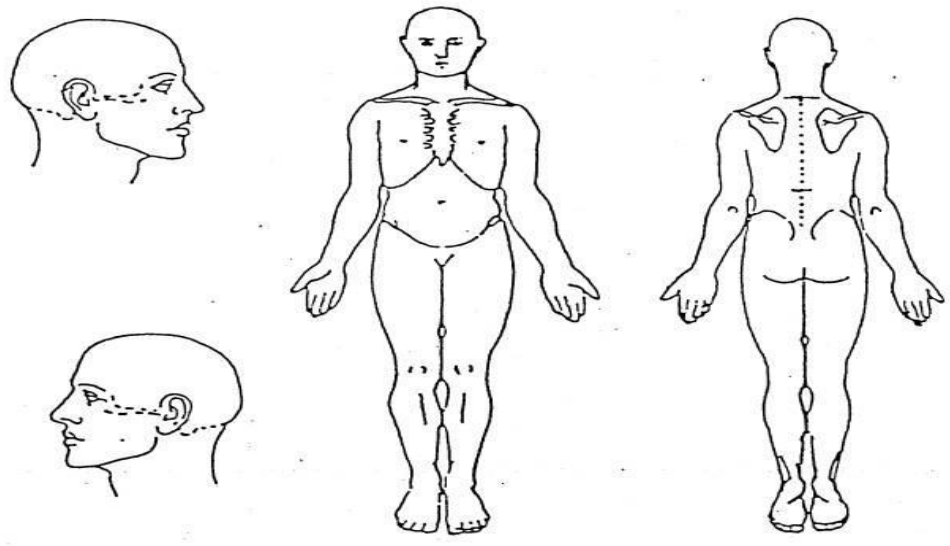
Current symptoms: _____

_____

Are the following foods prevalent (3x/week) in your diet?

☐ Tomatoes ☐ Potatoes ☐ Peppers ☐ Egg plant ☐ Tobacco

Please indicate on the diagram the location of your current symptoms:



Patient Name: _____ Date: _____

Patient Signature: _____

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Do you exercise? ☐ Yes ☐ No

If yes, what type of exercise? _____

How often? _____

Pain Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Stress Level: (0 being none and 10 being the worst)

0 1 2 3 4 5 6 7 8 9 10

Please List All Operations/Surgeries:

Operation Performed (even as a child)	Year

Please check if YOU have had any of the following conditions

☐ Insomnia	☐ PTSD	☐ Phobias _____
☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke
☐ Mental Illness/Depression	☐ Candida (yeast allergy)	☐ Eating Disorder
☐ Diabetes (type I or II)	☐ Heart Attack/Disease	☐ Brain Injury
☐ Arthritis	☐ Celiac Disease	☐ Migraine Headaches
☐ Thyroid Dysfunction	☐ Asthma	☐ Blood Clots
☐ Cancer	☐ Dizziness	☐ Shortness of breath
☐ Alcoholism	☐ Anxiety	☐ Heart palpitations
☐ Substance abuse	☐ Irritable bowel syndrome	☐ Reflux
☐ Fibromyalgia	☐ Chronic fatigue syndrome	☐ Lyme disease
☐ Restless leg syndrome	☐ Diarrhea	☐ Concussion
☐ Carbon monoxide poisoning	☐ Difficulty swallowing	☐ Stuttering
☐ Multiple chemical sensitivity	☐ Difficulty speaking	☐ Attention deficit disorder
☐ Attention deficit hyperactivity disorder	☐ Empty Nest Syndrome	☐ Intrusive thoughts
☐ Sleep Apnea	☐ Miscarriage	☐ Sweaty hands/feet
☐ Night sweats	☐ Ulcers	☐ Hemorrhoids

Other conditions not listed: _____

Patient Name: _____ Date: _____

Patient Signature: _____

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Notice of Health Information Practices

This notice describes how information about patients may be used and disclosed and how patients can get access to this information. Please review it carefully.

Introduction

Peggy DeMaio LMT is committed to treating and using personal health information about all our patients responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes patient rights as they relate to personal health information. This applies to all personal health information as defined by federal regulations.

Understanding Health Records / Information

Each time a patient visits Peggy DeMaio LMT, a record of the visit is made. Typically, this record contains symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as the health or medical record, can possibly serve as a:

- Basis for planning care and treatment,
- Means of communication among the many health professionals who contribute to the care,
- Legal document describing the care received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing, via email and text.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
- Most likely uses of personal health information at Peggy DeMaio LMT.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Peggy DeMaio LMT, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy the health record (a reasonable fee may be required),
- Request an amendment of the health record,
- Obtain a list of the disclosures of the health information,
- Request a restriction on certain uses and disclosures of your information and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Peggy DeMaio LMT is required to:

- Maintain the privacy of the health information,
- Provide patients with this notice as to your legal duties and privacy practices with respect to information that we collect & maintain,
- Abide by the terms of this notice,
- Notify the patients if we are unable to agree to a requested restriction.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide the updated policy at the time of a future visit.

Patient Name: _____ Date: _____

Patient Signature: _____