

SonRidge Health & Healing Center

3750 US 1 South

St. Augustine, FL 32086

904-794-2121 phone 904-794-2138 fax

www.sonridgehealing.com

www.sonridgehealthsystems.com

the Sun of Righteousness...with healing on his wings

Malachi 4:2

WELCOME - A FEW REQUESTS

- **On the day of your appointment, please don't wear makeup, cologne, skin cream, oil, perfume, or other fragrant substances.**
- **Bring any recent medical records or test results that are applicable to your situation if you have access to them.**
- **Keep your phone turned off or on airplane mode. Having your phone on disrupts the frequencies.**
- **Please bring something to snack on. Your clinic visit may require 4 hours or more.**

THE FOLLOWING ARE VERY IMPORTANT FOR YOU TO BRING IN A ZIP LOCK BAG:

- **If you have animals, please bring in a sample of hair/fur/feathers.**
- **Pollen sample- please bring a swab that you rubbed on the bottom of the outside of your windshield.**
- **Bring in a sample of lint from your dryer or air filter in your home.**

Guests are welcome. Please advise any visitor not to wear perfume, cologne, after-shave or any other fragrant substance, including clothing that contains fragrant laundry detergent or fabric softener. To protect chemically sensitive patients, we may have to ask anyone smelling of fragrance to leave the building.

Yours in health,

Dr. Marty Monahan D.C., N.M.D.

**We treat many health challenges. Check out our testimonials on www.sonridgehealing.com
If you would like to give a testimonial, please notify our staff.**

SonRidge Health & Healing Center

SERVICES AND FEES

New Patient 3 Day Visit Includes:

\$1,750.00

- **3 office visits and custom remedies: Inflammation, Chemical, Drainage (Emotional Balance if needed)**
- **Frequency-Specific Electro-Homeopathics**
- **Sonridge Gentle Algorithmics**
- **Sonridge Plasma Frequency Emitter**
- **Neural Check**
- **Braintap Therapy**

OTHER SERVICES:

| | |
|--|--|
| Follow Up Appointment per day | \$450.00 |
| Remote Visit per day | \$350.00 |
| Chiropractic Adjustment | \$60.00 |
| Decompression | 1 area/\$75.00 or 2 areas/\$125 |
| Laser Therapy per session Package includes \$450/ 10 sessions | \$50.00 |
| Nasal Cranial Remodeling | \$200.00 |
| Red Light Helmet Therapy Package includes \$450/ 10 sessions | \$50.00 |
| PFE Therapy by the hour | \$150.00 |
| PEMF Therapy by the hour | \$100.00 |
| PFE & PEMF Therapy by the hour | \$200.00 |
| Body Electric Therapy | \$150.00 |
| Ionic Foot Bath/ session Package includes \$300/ 10 sessions | \$35.00 |
| Hyperbaric Oxygen Therapy 1 hour session Packages: 10 sessions for \$900 OR 20 sessions for \$1,700 | \$100.00 |

SONRIDGE HEALTH & HEALING CENTER
3750 US1 South, St Augustine, FL 32086
Martin Monahan DC, NMD

Initial Patient Info Date: _____

| | |
|---|--|
| Last Name, First Name, Middle Initial | |
| Gender (M or F) | |
| Birthdate (month/day/year ex. 05/25/1975) | |
| Email | |
| Phone Number (No Hyphens) | |
| Birthplace (ex. Orem, Utah, USA) | |
| Height (ex. 5 feet 6 inches) | |
| Weight (ex. 198lbs) | |
| Hair Color (as of age 8) | |
| Eye Color | |
| Current Address (include Street, City, State, & Zip) | |

Who can we thank for referring you to our practice? _____

Have you had the Covid-19 vaccine? _____ Date: _____

Have you had Covid? _____ Date: _____

Please list, in order of importance, your top 5 health concerns. These may include physical, mental, and emotional ailments.

1. _____

2. _____

3. _____

4. _____

5. _____

In case of emergency please call: _____

If pregnant or nursing, please alert staff.

- I. What symptoms are you having?

- II. Please list and date any disease name diagnoses you have received. (For example: “Lupus in 2012” , “Autoimmune Disease in 2015”, “Lyme in 2013”)

- III. Have you ever been diagnosed with cancer? If so, when, and where was it located?

- IV. What type of work do you do? Include occupation, hobbies, etc.

- V. Do you smoke? If yes, what, how much, and for how long?

- VI. Have you had any recent vaccinations? If yes, when?

- VII. Please list and date all surgeries you have received.

Were there any complications?

- VIII. Do you have a pacemaker or any other electronic implants? If yes, when did you receive it?

- IX. Have you ever had a root canal or tooth extraction, if so approximately when it was performed?

X. How well do you sleep? (Number of hours)

MEDICATION SUMMARY

- I. Please list ALL medications you are CURRENTLY taking. Include oral and topical preparations.

- II. In the past 2 years, have you taken any antibiotics or steroids? If yes, please list.

- III. Have you had any medical or dental surgical procedures in the past 2 years? If yes, was general, local, or spinal anesthesia used?

- IV. Have you used any recreational drugs within the last 2 years?
If yes, please list.

NAME: _____ DOB: _____

Personal Health & Wellness Consultation Waiver

Please initial each box, indicating that you have read, understand and agree with the statement.

_____ I fully understand that the attending practitioner is not an allopathic practitioner (Medical Doctor) and does not portray his/herself to be one but is a wellness consultant and Sonridge Analyzer practitioner.

_____ I fully understand the difference between the practice of allopathic (conventional) medicine, nutritional wellness consulting, and Sonridge Analyzer scans.

_____ I fully understand that the services provided by the attending practitioner are not allopathic but are strictly bio-electric in nature.

_____ Any reference to patient within this therapy is solely due to technical terminology and in no way implies that the client is a medical patient.

_____ I fully understand that the attending practitioner performs his/her services within the parameters of a natural health care and wellness system using the Sonridge Analyzer and stress reduction.

_____ I fully understand that the attending practitioner does not offer allopathic drugs, surgery, chemical stimulants, radiation therapy, or any other conventional treatments. In addition, he/she does not diagnose, treat, or otherwise prescribe for any disease, condition, or illness.

_____ I have solicited the attending Sonridge Analyzer practitioner's service in good faith, exercising my free will and following the dictates of my own conscious which allows me to select what I understand is most beneficial to my health.

_____ If I desire any services not provided by the attending Sonridge Analyzer practitioner, which is my prerogative, I fully understand that I should seek them elsewhere. A referral for such services can be arranged.

_____ I presently seek council, advice, opinions, Sonridge Analyzer or points of view and/or programs within the scope of the attending practitioner's wellness and stress reduction practice. I am fully aware and release the Sonridge Analyzer practitioner to do Sonridge Analyzer sessions.

_____ I fully understand that the services provided by the attending practitioner are not generally accepted and/or recommended by allopathic doctors (Medical Doctor) or other conventional health care professionals. I realize that insurance payment is not possible, and I understand that payment is expected at the time of service.

_____ By signing below, I acknowledge that I have read and understand all parts of this waiver and that I have had the opportunity to ask questions regarding all such procedures.

_____ I understand that returns are not accepted and will only be approved on a case-by-case basis, and for only unopened and unused items.

_____ The Food and Drug Administration has not evaluated these statements. This product is not intended to diagnose, treat, cure or prevent any disease.

_____ I further affirm that I am not acting in any capacity other than a natural person desiring a Sonridge Analyzer session. I further affirm that I am not acting as an agent for the American Medical Association, or any National, State or Local healing arts group. I further state that I am not an employee of, agent for, or in any way associated with a Foreign, Federal, State, or Local Entity and am acting solely for myself in requesting and taking part in this session or series of sessions. I further affirm that this session will not be used as an entrapment for any government, association, organization or given individual.

_____ With the acceptance of this Consent Agreement, I hereby waive and release myself and my heirs, executors and administrators, from any and all claims of any nature herein and do acknowledge that I will use the services provided at my own risk. I confirm that I have given accurate directions and that I am of legal age in this jurisdiction.

By signing this document, I acknowledge I have read each statement entirely and agree to the statements aforementioned.

Printed Name: _____

Signature: _____

Date: _____

Witness: _____

Date: _____

Guardian/Relationship: _____

**If the client is under the age of 18 years of age

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses or disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, closer personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April, 2004 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice for the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information: For more information about HIPPA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 2020
(202) 619-0257 Toll Free: 1-877-696-6775

PATIENT CONSENT FORM

I understand that, Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change it's *Notice of Privacy Practices* from time to time and what I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____