LEWC Inc. Health & Wellness Workshop Registration

Date:	**Name:**
Primary Caregiver Name (If different from Consumer):	***Date of Birth:**
Gender:	Employment Status:
Race/Ethnicity:	**Guardian Name:**
Street Address:	**Guardian Email:**
City/State/Zip:	**Guardian Phone:**
Consumer's Phone #:	Marital Status:
What is the Highest Grade Level completed:	Do you have any needs for special accommodations for hearing impairment, vision impairment, mobility, or trouble reading? (specify): __Hearing Impaired _ Vision _Mobility Other:________
Do you have an Email Address?:	What office would you prefer? Salisbury, Easton, or Cambridge Online Telehealth/Wellness Services Prefered Office:
Primary Medical Information: Doctors Name: Doctors Phone: Doctors Address	Allergies:

❏ Magazine - Specify:____________________________ ❏ Newspaper - Specify:___________________________ ❏ Other - Specify:______________________________ ❏ Churches ❏ County Program - Specify: ❏ Day Care Center ❏ Employer ❏ Facebook / Social Media ❏ Former Consumer/Client ❏ Google / Internet search engine	❏ Epic In-Basket Message ❏ In-Store Advertising ❏ Insurance Company ❏ Primary Care Provider ❏Specialist Provider ❏ Word of Mouth ❏ School ❏ Seminars ❏ Physician Rating Website ❏ Agency Website

I ______________________Authorize participation in LEWC Inc Wellness Workshops voluntarily and release and discharge LEWC Inc. Staff, Volunteers, Contractors and representatives from any liability or responsibility for damage and or injury sustained by attending LEWC Inc. Wellness Workshops. I give my Permission and Consent for Program Participation and or Treatment with Life's Energy Wellness Center Inc. (LEWC Inc.). I hereby assign my insurance benefits to be paid directly to the service provider and or agency Life's Energy Wellness Center Inc.. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or co-insurance. I authorize and give consent for Life's Energy Wellness Center Inc., its affiliates, and provide Precision Labs to bill me directly for recommended services performed that are not covered under the terms of my health insurance plan(s). I authorize Life's Energy Wellness Center Inc., the provider, designated representative(s), or automated robot to contact me by email, text, and or telephone about appointments, billing, and medical care. I authorize the Life's Energy Wellness Center Inc. its affiliates permission to release any medical information required to process insurance claims. I acknowledge that I have been offered and viewed a copy of the "Notice of Privacy Practices" and the "Consumer Handbook" I understand a fee for missed appointments may apply (*see Consumer Handbook*).

Signature of Participant:____ Date:____________
Parent or Legal Guardian Signature: ______________________________ Date:____________

Staff Signature:________________________ Date:__________________________
Scheduled Consultation Appointment Office/Day/Time/Staff:_______________________
rev.2/2022

Staff Signature:___________________________ Date:______________________________

Scheduled Consultation Appointment Office/Day/Time/Staff:_________________________