

***Holistic Harmony MedSpa***  
*Balancing the Mind, Body, and Spirit*

**Personal Information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Gender: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Social Information**

Occupation: \_\_\_\_\_ Hours of work per week: \_\_\_\_\_

Relationship Status: \_\_\_\_\_ Spouses Name: \_\_\_\_\_

**HIPPA Compliance**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services or medical services and under the federal regulations governing confidentiality, and cannot be disclosed without my written consent.

**Authorization for Treatment**

I consent for the above named person to receive treatment from Debbie Reynolds, MSN, FNP, PMHNP, BC, nurse practitioner, Holistic Harmony MedSpa.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_