ACTIVE WELLNESS
ACUPUNCTURE | CHIROPRACTIC & MASSAGE

Confidential Patient Information

Dr. Nelson Valentin
Dr. Keli Kepler
(206)547-9944
(206)547-1323 Fax

Date: _____First Name: _____ Last Name: _____ Initial: _____

Personal Information

Address: _____ City: _____ State: _____Zip: _____

(Check best way to contact you) ❍ Home Phone: _____ ❍ Cell Phone: _____

❍ Work Phone: _____ ❍ Email: _____

Sex: ❍ M ❍ F Soc. Security #: _____-_____-_____ Age: _____ Date of Birth: _____

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍Widowed ❍ Separated ❍ Partner Spouse Name: _____

# of children: ____ Occupation/Job Title: _____

Employer: _____ Employer's Phone: _____

How were you referred to Active Wellness? _____

Is your visit a result of a work or auto accident? ❍ Yes ❍ No If yes, please see receptionist for injury report form.

Would you like Appointment reminders? ❍ Email ❍ Text Cell Carrier Network:_____

Insurance Information ~ Give ID and Insurance card(s) to Receptionist.

Insurance Company: _____ ID Member Number: _____Group Number: _____

Secondary Coverage: _____ ID Member Number: _____Group Number: _____

Do you have an accident attorney? ❍ Yes ❍ No Name: _____

Emergency Contact Name: _____ Relation: _____

Contact Number: _____Address:_____

Major Complaint Information

What is your major complaint(s)? _____

When did this (these) symptom(s) begin? _____

Have you experienced these symptoms before? ❍ Yes ❍ No When? _____

These symptoms developed from? ❍ Auto Accident ❍ Work-Related ❍ Other: _____

Have you reported this injury to your: Insurance Company ❍ Yes ❍ No Employer ❍ Yes ❍ No

What aggravates this condition? _____

What decreases the symptoms/pain? _____

Does heat affect the pain? ❍ Yes ❍ No If so, how? _____

Does cold affect the pain? ❍ Yes ❍ No If so, how? _____

Have you seen a doctor for this condition? ❍ Yes ❍ No Doctor's Name: _____

Date Consulted: _____ Diagnosis: _____

Were X-Rays taken? ❍ Yes ❍ No Facility:_____

Have you seen a chiropractor, massage therapist or acupuncturist before? ❍ Yes ❍ No

Name of Practitioner: Date: Name of Practitioner: Date:

_____ _____ _____ _____

Do you have a family physician? ❍ Yes ❍ No Name of physician: _____ Phone number: _____

Address: _____City/State/Zip: _____

Have you missed work because of these injuries? ❍ Yes ❍ No From: _____ to _____

If female, are you pregnant? ❍ Yes What is your due date? _____ ❍ No ❍ Not Sure Last menstrual cycle? _____

Any additional information you would like the doctor to know before beginning care at Active Wellness? _____

Have you been treated by any health care provider for ANY health conditions in the last 12 months? ❍ Yes ❍ No

Describe condition: _____Date of last Physical Exam: _____

Have you ever had any surgeries or hospitalizations? ❍ Yes ❍ No Please List:

Type of Hospitalization/Surgery: Date: Type of Hospitalization/Surgery: Date:

_____ _____ _____ _____

_____ _____ _____ _____

Have you had MRI, CT or X-Rayed in the last 12 months? ❍ Yes ❍ No Facility?_____

Does this condition interfere with your sleep? ❍ Yes ❍ No

If so, how many times do you wake up in pain per night? _____

In what position do you sleep? ❍ Back ❍ Stomach ❍ Side

Do you sleep with a pillow? ❍ Yes ❍ No How many? _____

Do you wear a heel lift? ❍ Yes ❍ No If so, which side? ❍ Right ❍ Left

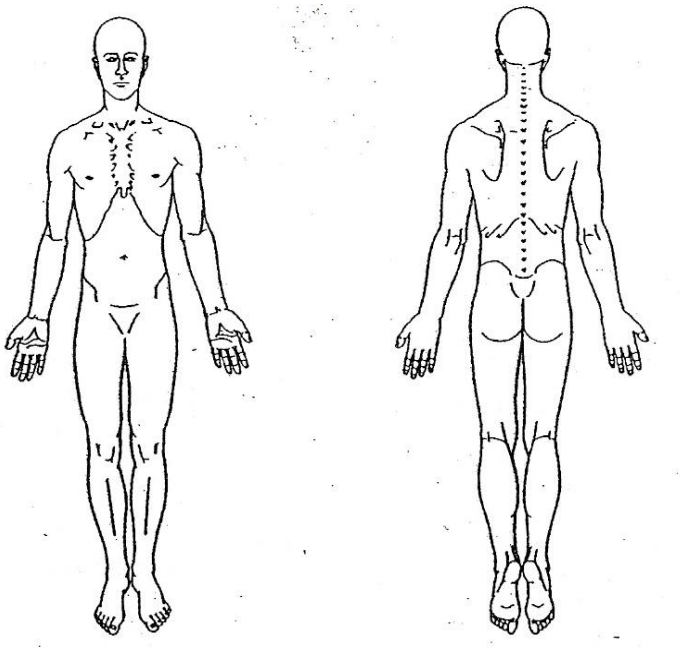
Using the symbols provided in the Pain Index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1-10 indicating the extent of the pain. (1 being minor and 10 being severe)

Pain Scale

0 1 2 3 4 5 6 7 8 9 10

[_____[_____[_____[_____[_____[_____[_____[_____[_____[_____]

No Pain Moderate Pain Severe Pain



Pain Index

B Burning **S** Sharp/Stabbing **N** Numbness

For example: if you are experiencing moderately severe burning pain in your neck, you should note "B5" on the neck of the illustration.

If this is an injury, describe what happened:

_____

_____

_____

_____

_____

_____

_____

_____

_____

activewellness.seattle@outlook.com 2223 N 56 Street, Seattle, WA 98103 P206.547.9944 F206.547.1323

Check those activities below during which you experience difficulty or pain:

___ Lying on back	___ Getting in/out of car	___ Sleeping	___ Stooping	___ Standing for periods over 1 hour
___ Lying on side w/ knees bent	___ Gripping	___ Pushing	___ Sitting	___ Bending forward
	___ Climbing	___ Pulling	___ Coughing	___ Sneezing
___ Turning over in bed	___ Dressing self	___ Reaching	___ Walking	___ Bending Backward
___ Lying on stomach	___ Sexual activity	___ Kneeling	___ Other: _____	

Additional Complaints

Headaches

Do you have a family history of headaches? ❍ Yes ❍ No Do you get headaches? ❍ Yes ❍ No Frequency? _____

Do you experience the following with your headaches: Pain or cracking in your jaw? ❍ Yes ❍ No

Abnormal blood pressure? ❍Yes ❍ No ❍ High ❍ Low Nausea, vomiting or visual disturbances? ❍ Yes ❍ No

When was your last eye exam by a doctor? ❍ 1-6 months ❍ 6-12 months ❍ 1-2 years ❍ over 2 years Results? _____

Neck Pain

If you have a neck injury, does it effect: (Check all that apply) ❍ Hearing ❍ Vision ❍ Balance ❍ Ringing in ears

Do you hear grating sounds? ❍ Yes ❍ No Do you feel pressure or pain behind your eyes? ❍ Yes ❍ No

Do you feel ripping or tearing? ❍ Yes ❍ No Where? _____

Do you have difficulty lifting or turning your head? ❍ Yes ❍ No If so, which direction? ❍ Right ❍ Left ❍ Up ❍ Down

Lower Back Pain

Do you ever experience a ripping or tearing sensation in your back? ❍ Yes ❍ No If so, where? _____

Does the pain radiate to the abdomen? ❍ Yes ❍ No

Do you ever have impaired bowel or urinary function? ❍ Yes ❍ No Explain: _____

Medical History ❍Allergies: _____

❍ Asthma/ COPD	❍ Venereal Disease	❍ Heart Disease	❍ Autoimmune	❍ Shortness of Breath
❍ Convulsions	❍ Memory Loss	❍ Flushed Face	❍ Cold Hands	❍ Nervousness
❍ Digestive Disorder	❍ Cold Feet	❍ Arthritis	❍ Jaw Pain	❍ Vision Problems
❍ Dizziness	❍ Fainting	❍ Vomiting	❍ Nausea	❍ Loss of Taste
❍ Excessive Perspiration	❍ Sinus Trouble	❍ Migraines	❍ Loss of Smell	❍ Eyes Sensitive to Light
❍ Headaches	❍ Heart Disease	❍ Fatigue	❍ Insomnia	❍ Pain behind Eyes
❍ HIV (Aids)	❍ Diarrhea	❍ Palpitation	❍ Chest Pain	❍ Loss of Balance
❍ Loss of Concentration	❍ Irritable Bowel	❍ Anxiety	❍ Depression	❍ German Measles
❍ Loss of Consciousness	❍ Concussion	❍ Hypertension	❍ Diabetes	❍ Hepatitis
❍ Tingling Arm/Leg	❍ Epilepsy	❍ Anemia	❍ Constipation	❍ Tuberculosis
❍ Multiple Sclerosis	❍ Mood Swings	❍ Thyroid	❍ Polio	❍ Rheumatic/Scarlet Fever
❍ Heavy Feeling in Head	❍ Neck Pain/ Stiffness	❍ Right/Left Shoulder Pain		❍ Right/Left Leg/Foot Pain
❍ Right/Left Arm/Hand Pain		❍ Mid-Back Pain/Stiffness		❍ Cancer _____
❍ Upper Back Pain/Stiffness		❍ Low Back Pain/Stiffness		❍ Addiction _____

Please Specify Locations: ❍ Bruising _____ ❍ Swelling _____
❍ Numbness _____ ❍ Cuts _____
❍ Bleeding_____

Social History

Exercise amt:	❍ Never	❍ Seldom	❍ Occasional	❍ Regularly
Tobacco use:	❍ None	❍ Light	❍ Moderate	❍ Heavy
Alcohol use:	❍ None	❍ Light	❍ Moderate	❍ Heavy
Caffeine use:	❍ None	❍ Light	❍ Moderate	❍ Heavy
Drug use (Rx or OTC):	❍ None	❍ Light	❍ Moderate	❍ Heavy

List all medications you are taking now, including over the counter medications and recreational drugs:_____

List any vitamins, herbs or supplements in the last 3 months:_____

Are you allergic to any medication: ❍ Yes ❍ No ❍ Not Sure Please list:

_____

Do you have, or have you ever had, any diseases or medical problems not listed above? ❍ Yes ❍ No If so, please list:

activewellness.seattle@outlook.com 2223 N 56 Street, Seattle, WA 98103 P206.547.9944 F206.547.1323

Auto Accident Information

(Please allow the receptionist to copy the Police Report)

Accident Date: _____ Accident Time: _____ At Fault Person's Name: _____

Accident Location: _____ City: _____State: _____

List what symptoms you suffer with as a result of the accident?

1. _____
   ❍ Occasional ❍ Comes & Goes ❍ Frequently ❍ Constant Rate intensity: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe
2. _____
   ❍ Occasional ❍ Comes & Goes ❍ Frequently ❍ Constant Rate intensity: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe
3. _____
   ❍ Occasional ❍ Comes & Goes ❍ Frequently ❍ Constant Rate intensity: No Problem 0 1 2 3 4 5 6 7 8 9 10 Severe

Were you the: ❍ Driver ❍ Passenger ❍ Front ❍ Back _____ # of people in the car.

Did you wear a Seatbelt? ❍ Yes ❍ No Did the airbags deploy? ❍ Yes ❍ No

Road Conditions: ❍ Wet ❍ Dry ❍ Slippery Time of day?_____

Estimated damage to patient's car: _____

Did your vehicle spin or rollover? ❍ Yes ❍ No

Did your vehicle get hit into another: ❍ Vehicle ❍ Object ❍ None

Were you aware you were about to be in an accident? ❍ Yes ❍ No

Did you brace yourself? ❍ Yes ❍ No ❍ Don't remember

Did you have your foot braced on: ❍ floor board ❍ brake ❍ neither

Were your hands on the wheel? ❍ Yes ❍ No

Was your head turned at the time of impact? ❍ Yes ❍ No ❍ Right ❍ Left ❍ Don't remember

Were you leaning forward at time of impact? ❍ Yes ❍ No ❍ Don't remember

Was your body turned at time of impact? ❍ Yes ❍ No ❍ Right ❍ Left ❍ Don't remember

Did you hit your head or any other part of your body on anything inside the car? (For example knees, elbows, seatbelt, headrest)
❍ Yes ❍ No ❍ Don't remember Explain: _____

Did you feel: ❍ Dazed ❍ Disoriented ❍ Have patchy loss of time Did you see stars/checkerboard vision? ❍ Yes ❍ No

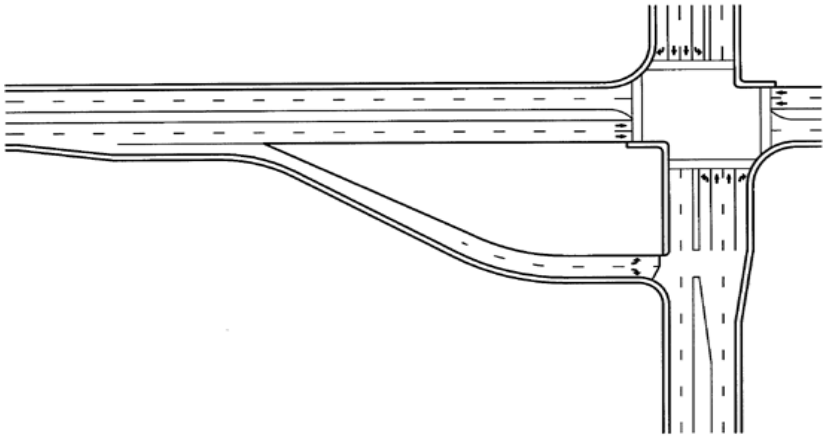
Were you rendered unconscious? ❍ Yes ❍ No ❍ Don't remember

What is the first thing you remember after the impact? _____

If considerable time has lapsed since the trauma, why did you wait so long to seek treatment/evaluation? _____

In your lifetime have you had any other accidents/traumas/injuries? ❍ Yes ❍ No When were they? _____

Please fill out the diagram (as applicable):



Please note the events that occurred:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

activewellness.seattle@outlook.com 2223 N 56 Street, Seattle, WA 98103 P206.547.9944 F206.547.1323

Informed Consent

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I will be responsible for any costs of collection, attorney's fees or court costs required to collect my bill.

I hereby authorize physicians and staff at Active Wellness (aka Keys to Health Inc) to treat my condition as deemed appropriate. It is understood and agreed the amount paid to the doctor for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen any time. The doctor will not be held responsible for any pre-existing medically diagnosed conditions.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any staff member of Active Wellness responsible for any errors or omissions that I may have made in the completion of this form.

Health care modalities are associated with potential risks in the delivery of treatment. Therefore it is necessary to inform the patient of such risks prior to initiating care. While chiropractic, acupuncture and massage treatments are remarkably safe, you need to be informed about the potential risks related to your care to allow you to be fully informed before consenting to treatment.

We cannot promise a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can further assist you.

Specific Risk Possibilities Associated with Chiropractic Care.

Soreness- Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post treatment soreness. This is a normal and acceptable accompanying response to care. Advise your doctor if you experience soreness or discomfort.

Soft Tissue Injury- Occasionally chiropractic treatment may aggravate a disc injury or fracture. Precautions such as pre-adjustment x-rays are taken for cases considered at risk. Treatment is performed carefully to minimize such risk.

Rib Injury- Manual adjustments to the thoracic spine, in rare cases, may cause rib injury or fracture. Precautions such as pre-adjustment x-rays are taken for case considered at risk. Treatment is preformed carefully to minimize such risk.

Stroke- The most serious complication of chiropractic care. The most recent studies (*Journal of the CAA*, Vol. 37 No. 2, June 1993) estimate that the incidence of this type of stroke is 1 in every 3 million upper cervical adjustments.

Specific Risk Possibilities Associated with Acupuncture Care.

Bruising- Also a side effect of cupping, along with numbness, tingling at the needle sites is common.

Uncommon side effects- Spontaneous miscarriage, nerve damage, organ puncture and infection are quite rare.

If you have any questions concerning this form or the above statements, please ask your doctor.
Having carefully read the above, I hereby give my consent to have treatment administered to myself or the person named below.

_____ _____

Patient Signature Date

_____ _____

Parent/Legal Guardian Signature Date

Agreement to Payment in Full

ACTIVE WELLNESS
ACUPUNCTURE CHIROPRACTIC & MASSAGE

Patient Name: _____

Date of Injury: _____

To Attorney: _____

The undersigned patient (hereafter "patient") of hereafter "Active Wellness Chiropractic" authorizes the clinic to furnish my attorney named above (hereafter "attorney") with all documents relating to my care for the injury of above date (hereafter injury") that are in possession of clinic, regardless of where or by whom such documents originated.

I authorize and direct my attorney to pay to the clinic all such sums as may be due and owing the clinic for treatment relating to my injury. I specifically direct my attorney to withhold such monies out of any award or settlement that would be otherwise net payable to me when my claim for injuries resolves.

I acknowledge full responsibility for payment of all my bills owing to the clinic. I also specifically agree that the clinic may withhold collection on my account in exchange for my promise to have my attorney pay my bills out of any resolution of my injury claim. I agree not to rescind the terms of this agreement, and I direct my attorney to not be bound by any attempt at rescission on my part. I hereby direct that my attorney pay my bill to Active Wellness Chiropractic out of monies that would be otherwise net payable to me at the time of resolution of my claim.

This direction to my attorney in no way releases me from the obligation to pay the clinic on my bill and I understand that this obligation to pay is not contingent on my recovering on my claim, I agree that if the clinic is not paid on my account, the clinic may take whatever collection efforts it chooses against me, and I shall be responsible for all costs of collection including reasonable attorneys fees and costs incurred by the clinic or its collecting monies owed by me.

I have been advised by the clinic that if my attorney does not wish to sign this document, that the clinic may declare my entire bill due and owing at any time clinic chooses. If the patient is a minor or incompetent person, I represent that I am the guardian or representative of that person and have lawful representation.

Dated: _____ Patient's Name (printed): _____

Patient's Signature: _____

Acknowledgement of Attorney

The undersigned, being attorney for above named patient in the claim for injuries of above stated date, agrees to the above terms and agrees to withhold from any settlement, award, judgment, or verdict any monies that would be otherwise net payable to patient in resolution of patient's claim.

Date: _____ Attorney's Name (printed): _____

Attorney's Signature: _____

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In the course of your care as a patient at Active Wellness we may use or disclose personal and health related information about you in the following ways:

- Your protected health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of services provided to you.
- Your name, address, phone number, e-mail address, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, or other health related information that may be of interest to you.
- If you are not home to receive an appointment reminder or other related information, a message may be left on your answering machine or with a person in your household. You have a right to confidential communications and to request restrictions relative to such contacts. You also have the right to be contacted by alternative means or at alternative locations.
  You have a right to request restrictions on our use of your protected health information for treatment, payment and operations purposes. Such requests are not automatic and require the agreement of this office. We are permitted and may be required to use or disclose your health information without your authorization in these following circumstances:
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

You have a right to receive an accounting of any such disclosures made by this office. Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization. If you provide an authorization for release of information you have the right to revoke that authorization at a later date. Information that we use or disclose based on this privacy notice may be subject to redisclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules. We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a specific form please advise us in writing as to your preferences.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information, and are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files. If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, or if you would like further information about our privacy policies and practices please contact:

Nelson Valentin- Privacy Officer at 2223 N 56 Street, Seattle, WA 98103 (206) 547-9944

You also have the right to lodge a complaint with the Secretary of the Department of Health and Human Services. If you choose to lodge a complaint with this office or with the Secretary your care will continue and you will not be disadvantaged by this office or our staff in any manner whatsoever.

This office utilizes an "open adjusting" environment for ongoing patient care. "Open adjusting" involves several patients being seen in the same general adjusting area at the same time. Patients are within sight of one another and some ongoing routine details of care are discussed within earshot of other patients and staff. This environment is used for ongoing care and is NOT the environment used for taking patient histories, providing examinations or presenting reports of findings. These procedures are completed in a private, confidential setting. The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. If you choose not to be adjusted in an open-adjusting environment other arrangements will be made for you.

This notice is effective as of December 01, 2017. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____ _____

Name (Please Print) Signature Date

Active Wellness Financial Policy

Cancellation Policy: 24 hours prior notice required to cancel or reschedule your appointment. More than 2 missed appointments without notice will result in a $65 charge. Missed appointments are your responsibility and can never be billed to your insurance!

Payment Arrangements: We understand there are times you may not be able to pay your bill in full. It is your responsibility to call us to arrange special payments. Failure to maintain your account in good standing could result in your account being forwarded to collections and your liability increased. We accept cash, checks, debit cards, most credit cards and also offer *auto debit* for your convenience. **There will be a $35.00 fee (per RCW 2a.a-515 & 520) on checks returned due to non-sufficient funds (NSF, closed accounts, etc).**

Advanced Beneficiary Notice and Waiver Forms: Certain visits and procedures may not be covered by your insurance plan. Your signature on this ABN form signifies you have been made aware of these policies.

Insurance: *Active Wellness Acupuncture Chiropractic & Massage* participates with most major insurance carriers. It is your responsibility to provide us with the current information necessary for billing including your government-issued ID, address, phone number and a copy of your insurance card at each visit. Per insurance rules, **all co-payments are due at the time of service**.

Your insurance is a contract between you and your insurance carrier, which may not cover all services. Do not be surprised if we make care recommendations above and beyond what your insurance will cover. Insurance is designed to cover emergencies and crisis, not restoration and wellness. **Ultimately, you will be responsible for the cost of all services above and beyond what your insurance will cover.** You will receive a statement for any balance left on your account and are due upon receipt of your statement.

We do our best to verify your insurance benefits but we do not pay your premiums - you do. We cannot accept responsibility for non-covered insurance claims, nor negotiate any disputed claim for you. It is your responsibility to verify your chiropractic, acupuncture & massage benefits and plan limitations. Keep in mind that insurance companies do not always share with us what they tell you; therefore any verbal statement of benefit eligibility does not guarantee coverage.

Our contracts with insurance companies say we must collect the following three items at your visit:
Deductible: The amount your insurance company wants you to contribute to your care before your benefits start.
Co-pay: The amount your insurance company requires you to pay at each visit, which may not apply to your deductible.
Co-Insurance: Your share of the coverage percentage that is split between you and your insurance carrier.

Referrals: Some insurance plans require a referral or a pre-authorization prior to your appointment. It is your responsibility to ensure this has been obtained or your insurance carrier may deny payment and the resulting balance becomes your responsibility.

Motor Vehicle and Third-Party Billing: These claims are your financial responsibility. We will provide documentation for you to submit as evidence of services rendered. Claims that are not paid within 30 days become your responsibility.

Options to Pay:

1. Pay at the time of service: All applicable service fees are collected at the time of service. Please see our Price Menu for a breakdown of each service's charged. We accept cash, check, debit, and most major credit cards**.** Uninsured Patients: If you don't have insurance coverage, please be prepared to pay $150 for your initial visit and $50 for each subsequent visit ($102 for massage) with the same provider.

2. Utilize your insurance: We are In-Network for most of the major insurance carriers and will bill rendered services to your insurance company on your behalf. If you have insurance, we are under contract by the insurance companies to utilize it. If you have insurance but choose not to utilize it, you must sign a document acknowledging this choice.

3. Payment Plans: This is a system of payments that group visits together in order for you to receive the benefit of spreading out the total investment into multiple smaller payments. If you utilize this option, all services not received are 100% refundable. This option only applies to cash plans and cannot be done with insurance. **Traction and Extremity Adjustments are not factored into payment plans, so if you choose to receive one, the respective $30.00 fee will be due at the time of service.**

I have read and understood the payment options available to me. I also consent to the terms and conditions above.

Signature:_____ Date:_____

activewellness.seattle@outlook.com 2223 N 56 Street, Seattle, WA 98103 P206.547.9944 F206.547.1323

Active Wellness Price Menu

Service Type	TOS	Insurance Fee
Initial Evaluation	100.00*	150- 250.00
Progress Assessment	50.00*	90.00
Report / Consultation	25.00*	30.00
Spinal Adjustment	50.00*	63- 75.00
Extremity Adjustment	35.00	35.00
Mechanical Traction	20.00*	30.00
Therapeutic Exercise	30.00*	40.00
Acupuncture	50-75.00*	108.00
Cupping	30.00*	40.00
Massage Therapy	25.50* (per 15 minute unit)	36.50 (per 15 minute unit)

** Because we do not have the financial burden of billing to and following up with an insurance company, we are able to offer a discounted rate to our practice members paying out-of-pocket for Wellness Care.*

Office Hours

Monday – Wednesday – Friday
9-1 and 2-6
Tuesday – Thursday
2-6
Call for Saturday morning appointments!

New Patient Orientation
Every Tuesday at 6:15 PM
Learn more about the benefits of healthy postures and stretches with Dr. Keli Kepler.

Health & Healing
Every Wednesday at 6:15 PM
Learn about reflexology, meditation and nutrition presented by Master Acupuncturist, Dr. Nelson Valentin.

Pre-Registration is requested for both classes.

2223 N. 56th St. Seattle, WA 98103 ph. 206.547.9944 fax. 206.547.1323

Client copy – please retain for future reference.