Alqimind Wellness
Comprehensive Client Intake, Consent & Privacy Acknowledgment Form

P: (305) 942–5246 | F: (305) 845–5673 | contact@alqimind.com | www.alqimind.com

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Welcome to Alqimind Wellness!

Please complete this form to help us understand your needs and provide the best possible care. All information will be kept confidential.

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1. Personal Information

Full Name: _____
Date of Birth: _____ **Age:** _____ **Gender:** _____
Phone Number: _____**Email:** _____
Emergency Contact: (☐ Authorized to discuss medical details)
Name: _____ **Phone Number:** _____
Relationship: _____
Address:_____
City: _____ **State:** ____ **Zip Code:** _____
Social Security Number (SSN): _____

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2. Health & Wellness Goals

What are your primary health and mental wellness goals? (Check all that apply)
☐ Stress Reduction & Emotional Well-being
☐ Increased Energy & Vitality
☐ Weight Loss & Metabolic Health
☐ Hormonal Balance & Optimization
☐ Improved Skin & Aesthetic Wellness
☐ Cognitive Function & Focus Support
☐ Psychiatric Evaluation & Medication Management
☐ Other: _____

Medical & Mental Health History
List any current or past medical or mental health conditions, including hospitalizations, substance use history, or suicide risk:

Current Medications & Supplements
List any medications, supplements, or treatments you are currently using:

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3. Lifestyle & Stress Assessment

Do you currently:

- **Exercise regularly?** ☐ Yes ☐ No
  If yes, type and frequency: _____
- **Follow a specific diet?** ☐ Yes ☐ No
  If yes, please describe: _____
- **Use substances such as alcohol, tobacco, or recreational drugs?** ☐ Yes ☐ No
  If yes, describe: _____
- **How would you rate your sleep quality?** (1 = Poor, 10 = Excellent)
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Describe any mental health concerns or stressors you are experiencing:

Have you received psychiatric or mental health treatment before? ☐ Yes ☐ No
If yes, please describe (e.g., therapy, medication, hospitalization):

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4. Acknowledgment of Services & Risks

✓ Alqimind Wellness provides psychiatric, holistic, and functional medicine services, including psychiatric evaluation, medication management, IV therapy, hormone therapy, weight management, aesthetics, and mental wellness care.
✓ Certain functional and holistic treatments may have limited research and are not FDA-approved for specific conditions. These treatments are elective and not a substitute for primary medical care.
✓ I consent to telehealth services and understand the benefits and risks.
✓ Individual results vary, and no guarantees are made regarding outcomes.
✓ I must disclose my full medical and psychiatric history to ensure safe and effective treatment.

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5. Privacy & Confidentiality Notice (HIPAA Compliance)

✔ I acknowledge that I have received and reviewed Alqimind Wellness's Notice of Privacy Practices, which explains:

- How my personal health and psychiatric information may be used and disclosed.
- My rights under HIPAA regarding access to my health records.
- Confidentiality protections and exceptions required by law.

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6. Psychiatric Treatment & Medication Consent

✔ Medication Management: I understand the risks, benefits, and potential side effects.
✔ Therapy Recommendations: Therapy may be recommended alongside or instead of medication.
✔ Treatment Compliance: I agree to scheduled follow-ups as needed.
✔ Medication Risks: Psychiatric medications can have side effects, interactions, and withdrawal symptoms.

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7. Financial Responsibility & Policies

- Payment is due at the time of service.
- A 24-hour cancellation policy applies. Late cancellations or no-shows will incur a fee of $50 (or as updated in clinic policies).
- All payments are final unless a service is canceled by Alqimind Wellness.
  ✔ I accept financial responsibility for all services received.

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8. Liability Waiver & Arbitration Agreement

✔ I assume all risks associated with treatments.
✔ I release and hold harmless Alqimind Wellness from any claims, liabilities, or damages.
✔ Alqimind Wellness does not provide emergency crisis intervention services.
✔ Any dispute shall be resolved exclusively through binding arbitration.
✔ I understand that arbitration does not prevent me from filing complaints with state medical boards or other regulatory agencies.
✔ I may opt out of this arbitration agreement within 30 days.
✔ Arbitration shall follow the rules of the American Arbitration Association (AAA).
✔ I waive my right to a jury trial.
✔ This agreement is governed by the laws of the State of Florida.

9. Emergency & Crisis Protocol

In case of crisis, I agree to:
✓ Call 911 or visit the nearest emergency room if in immediate danger.
✓ Utilize crisis resources such as:

- **National Suicide Prevention Lifeline:** Dial 988
- **Florida Crisis Line:** Call 211 for local mental health support
- **Local Emergency Psychiatric Services:** [Insert clinic-specific or regional resource]
- **Crisis Text Line:** Text HOME to 741741

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10. Consent & Signatures

✓ I certify that I have provided accurate information.
✓ I have read, understand, and agree to all terms outlined in this document.

Client Signature: _____
Date: _____

Practitioner Signature: _____
Date: _____

Legal Guardian Section (if applicable)

If the client is under 18 or legally unable to consent:
I, **(Legal Guardian Name)**, consent for Alqimind Wellness to provide treatments to my child.
✓ I acknowledge the treatment plan, risks, and benefits.
✓ I understand my child's assent will be considered.

Guardian Signature: _____
Date: _____