HOLISTIC HEALTH
ASSOCIATES

603-B W. Patrick St Frederick MD 21701 301-620-1414

Medical History – Acupuncture - Confidential

Name _____ **DOB _____** Today's date _____
Address _____ City _____ State _____Zip _____
Telephone: (home) _____ (cell) _____ (work) _____
Email _____ Married: Yes or No
Preferred means of contact: **(please indicate one):** ○text message ○email
Occupation _____ Employed by _____
Primary Care Doctor _____ Experienced Acupuncture/Herbs in the past? Y or N
How did you hear about us? _____
Referral-Who? _____ Internet-Which Search? _____ Yellow Pages Health Fair
BNI Print Ad/Article-Where? _____ Radio Sign Other _____

CHIEF COMPLAINT
Main problems you would like help with: _____
When did your issue(s) begin? _____ Did anything initiate symptoms? _____
Does anything make it worse or better? (such as heat, cold, massage, rest, fatigue etc.)
Explain:_____
Have you been given a diagnosis for this problem? If so, what? _____

Past Medical History / Family History

	Family	Yes	No		Family	Yes	No		Family	Yes	No
Diabetes	□	□	□	Osteoporosis	□	□	□	Blood clots	□	□	□
Chest Pain/Angina	□	□	□	Asthma	□	□	□	Peripheral Vascular Disease	□	□	□
High Blood Pressure	□	□	□	Stroke	□	□	□	Tuberculosis	□	□	□
Heart Disease	□	□	□	Seizure	□	□	□	Depression	□	□	□
Heart Attack	□	□	□	HIV / AIDS	□	□	□	Congestive Heart Failure	□	□	□
High Cholesterol	□	□	□	Hepatitis	□	□	□	Thyroid Disease	□	□	□
Pacemaker	□	□	□	Stomach Ulcer	□	□	□	Other (please list below)			
Headaches	□	□	□	Liver Disease	□	□	□	□			
Kidney Stones	□	□	□	Heart Palpitations	□	□	□	□			
Kidney Disease	□	□	□	Arthritis	□	□	□	□			
Cancer	□	□	□	Heart Surgery	□	□	□	□			

ROS	**Circle all that apply** - currently experiencing
Constitutional/ General	Weight loss – Fevers – Chills - Poor Appetite – Fatigue - Weight gain – Insomnia - Night Sweats Sweat easily - Localized weakness – Peculiar - Tastes or smells - Poor Sleeping – Chills - Cravings
Eyes	Blurry vision - Eye pain - Eye discharge - Eye redness - Decrease in vision - Dry eyes Double vision – Floaters – Glasses – Cataracts - Eye strain - Night blindness
ENMT	Sore throat – Hoarseness - Ear pain - Hearing loss - Ear discharge - Nose bleeds - Tinnitus Sinus problems – Dizziness - Ringing in ears - Teeth problems - Concussions - Poor hearing Facial pain - Jaw clicks – Migraine - Color blindness – Earaches - Grinding teeth Lip or tongue sores - Headaches
Cardiovascular	Chest pain – Palpitations - Rapid heart rate - Heart murmur - Poor circulation - Swelling in extremities High blood pressure - Low blood pressure - Irregular heart beat - Cold hands or feet Blood clots – Dizziness – Phlebitis – Fainting - Difficulty breathing
Respiratory	Shortness of breath - Chronic cough - Coughing up blood - History of Tuberculosis Phlegm – Bronchitis - Pain with deep breath – Pneumonia - Asthma
Gastrointestinal	Nausea – Vomiting – Diarrhea – Constipation - Blood in stool - Frequent heartburn Trouble swallowing - Black stools - Bad breath - Abdominal pain or cramps Chronic laxative use – Gas - Rectal Pain – Belching – Indigestion - Hemorrhoids
Uro-genital	Frequent urination - Blood in urine – Incontinence - Painful urination - Urinary retention - Frequent UTIs Urgency to urinate - Decrease in flow - Unable to hold urine – Impotency - Sores on genitals Do you wake up to urinate: ____ If yes, how often : _____ Any particular color to urine: _____
Gyno (women)	Number of pregnancies:____ Number of births: ____ Age at first menses: ____ Birth Control: _____ Premature births - Miscarriages/Abortions

	# of days between menses: ____Duration of menses: ____ Date of last menses: ____ Heavy period - Light period - Painful periods - Clots with flow - Irregular periods - Vaginal discharge Vaginal Sores - Breast lumps - PMS
Skin	Rash – Hives - Hair loss - Skin sores or ulcers – Itching - Skin thickening - Nail changes Mole changes – Dandruff – Ulcerations – Eczema - Pimples
Musculoskeletal	Joint pain - Muscle aches - Frequent leg cramps - Muscle weakness - Bone pain - Joint swelling Back pain - Neck pain - Hand/ wrist pain - Shoulder pain - Knee pain - Foot /ankle pain - Hip pain
Neuropsycho	Anxiety – Depression - Alcohol or drug dependence - Suicidal thoughts - Panic attacks Use of anti-depressants – Seizures - Areas of numbness – Concussion - Bad temper - Dizziness Lack of coordination - Easily susceptible to stress - Loss of balance - Poor memory
Endocrine	Goiter - Heat intolerance - Cold intolerance - Strong thirst - Change in skin pigment - Excess sweating
Neurological	Seizures – Tremors – Migraines – Numbness - Dizziness/ vertigo - Loss of balance - Slurred speech Stroke
Hem/Lymphatic	Low blood count - Easy bruising - Swollen lymph nodes – Transfusions - Prolonged bleeding - Blood clots
Allergic/Immun	Allergic reactions - Hay fever - Frequent infections – Hepatitis - HIV positive – Positive tuberculin skin test (PPD)

Early Development: Were there any in-utero complications before you were born? Please describe any labor and delivery, natural or C-section, and how long breast fed: _____

_____

Significant traumas (auto accident, falls etc.): _____

Allergies _____

LIFESTYLE

Prescription Medications: _____

_____

Medicines, Vitamins, Herbs: _____

_____

Do you have a regular Exercise Program? _____ Describe: _____

_____

Describe your average daily diet:

Breakfast Lunch Dinner

_____

Smoke cigarettes? _____ How many per day _____

How much coffee, tea or caffeine per week? _____

How much alcohol do you drink per week? _____

Please describe any use of drugs for non-medical purposes _____

HOLISTIC HEALTH
ASSOCIATES
603-B W. Patrick St Frederick MD 21701 301-620-1414

Pain Disability Questionnaire

Date: _____

Instructions: These questions ask your views about how your pain NOW affects how you function in everyday activities. Please answer every question and make ONE number on EACH scale that best describes you feel as it relates to the **CHIEF COMPLAINT** you indicated on the first page.

1. Does your pain interfere with your normal work inside and outside the home?

Work normally Unable to work at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

2. Does your pain interfere with personal care (such as washing, dressing, etc.)?

Take care of myself completely Need help with all personal care

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

3. Does your pain interfere with your traveling?

Travel anywhere I like Only travel when absolutely necessary

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

4. Does your pain affect your ability to sit or stand?

No problems Cannot sit/stand at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things?

No problems Cannot do at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

6. Does your pain affect your ability to lift objects off the floor, bend, stoop, or squat?

No problems Cannot do at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

7. Does your pain affect your ability to walk, run, or exercise?

No problems Cannot do at all

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

8. Has your income declined since your pain began?

No decline Lost all income

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

9. Do you have to take pain medication to manage your pain?

No medication needed Medication throughout the day

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

10. Does your pain interfere with your ability to see the people who are important to you?

No problem Never see them

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

11. Do you need help with everyday tasks because of your pain?

Don't need help Need help all the time

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

12. Do you feel more depressed, tense, or anxious than before your pain began?

No depression / tension Often depressed / tense

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

13. Does your pain cause emotional problems that interfere with your family, social, and or work activities?

No problems Severe problems

0---------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

Office use only: **Total: _____**

I certify that pgs 1-3 of the Medical History – Acupuncture and Pain Disability Questionnaire forms were reviewed.

_____ _____

Signature of reviewing practitioner Date

HOLISTIC HEALTH
ASSOCIATES

603-B W. Patrick St Frederick MD 21701 301-620-1414

Informed Consent for Care

I hereby request and consent to the performance of acupuncture, massage therapy, and/or nutrition/health counseling treatments and other procedures within the scope of the practice of these respective forms of care on me (or on the patient named below, for whom I am legally responsible), by the practitioner indicated below and/or other licensed practitioners who now or in the future treat me while employed by, working or associated with or serving as back-up for the practitioner named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment related to acupuncture may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may be an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that these treatments are generally safe methods of care, but that they may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, albeit rare. There are other side effects that may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture, massage therapy, and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Name (print): x_____ Date: _____

Patient Signature: x_____ Date: _____

(or Patient Representative) (indicate relationship if signing for patient)

HOLISTIC HEALTH
ASSOCIATES

603-B W. Patrick St Frederick MD 21701 301-620-1414

Financial Policy

Many insurance policies do cover acupuncture care but this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for any unpaid balances for services, in addition to patient balances and deductible balances identified by your insurance. We will do our best to verify your insurance coverage. The information we receive is a QUOTE from the insurance and is specifically not a guarantee of benefits or payment for services.
We currently accept Aetna, Blue Cross Blue Shield, United, and Cigna. We are a group practice; the services that you will receive may be billed under numerous providers. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage:

Payment Arrangements

- If you have a policy that identifies a flat copay, we require that you pay the copay amount at the time of each visit. **Effective, June 30, 2014**, if your policy identifies a % liability, we require that you pay an approximate amount at the time of service. Amounts are as follows: 10% - $10, 20% - $20, 25% - $25, and so forth. Once the insurance carrier has processed the claim and designated the exact amount due, you will be credited for any over payment or billed for any remaining balance. In addition, if we are able to identify a consistent trend amount with your percent responsibility, we will update our records and collect the most common percent identified by your insurance, and any amounts more or less than the average amount, will be "balance billed".
- All credits are first applied to any other outstanding balances due before refund checks are issued. Any unpaid balances will be considered past due 45 days past insurance reimbursement. Past due balances may have an interest charge of 1.5% per month.

- In the event that your insurance benefits have not been verified prior to your first appointment, you will be responsible for payment at the time of the service, and will be reimbursed for that payment, once we receive and process reimbursement from your insurance company.

- Any service not covered, or coverage reductions made by your insurance carrier will be the patient's responsibility unless previous agreements have been made.

- If your account should go to collections for any reason, it will be the patient's responsibility for any court costs, attorney fees, and or collection costs incurred in collecting the account balance**.**

- All insurance payments are applied to your account. Any amounts paid by the patient at the time of service will be refunded once we receive reimbursement from the insurance company.

- Waiting for the insurance company to reimburse our Center is a courtesy and it may be withdrawn under certain circumstances. Patient is still responsible for payment in instances when insurance company does not reimburse our Center.

Assignment of Benefits

- By signing this form, you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt. You may also choose to opt out of insurance assignment by signing an insurance waiver provided by this office.
- In the event that we are an out of network provider or non-participating provider, this office will provide you with any paperwork necessary for you to submit a claim on your own, in which case payment should be sent directly to you. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to address those directly with your insurance adjuster or agent.
- Currently, we process the four major insurance carriers (Aetna, Blue Cross, Cigna, and United). We will also process when Medicare is primary and one of the above-named providers is secondary. In any other scenario we will assist you with acquiring reimbursement independently by providing any documentation needed for you to submit.
- If you change insurance companies or employers, or your policy is updated or changed, you agree to provide this office with the current information immediately.

If this office gives you any courtesy or accounting discount for treatment and you decide to drop out of care, then the standard fees will apply. This would include any non-insurance, prepaid treatments, in that any refund issued would be a remainder of the prepaid amount after the standard fees has been applied to the treatments provided up to that point.

Patient and payer obligation is not contingent upon the outcome of care.

I agree to pay for the cost of the treatment if my insurance company declines to pay for any reason.

Release of Information

By signing this form, you are also authorizing this office upon request from your insurance carrier the release of any medical or other information necessary to process the claim. You also acknowledge and request payment of government benefits either to myself or to the party who accepts assignment, namely this office.

We hope this answers any questions you might have concerning the financial policy of this office. Once again we welcome you to our office, and will be glad to answer any further questions that you might have.

I have read and fully understand the financial office policy and agree to abide by these terms.

Patient: _____ Date:_____

Signature

HOLISTIC HEALTH
ASSOCIATES

603-B W. Patrick St Frederick MD 21701 301-620-1414

PATIENT MISSED APPOINTMENT POLICY

It's our wish that each and every one of our patients receive the very best care and service possible. Your program consists of a specific series of treatments given over a pre-planned time span, to maximize results. We care deeply about your results and the results of our other patients who are trying to maintain their programs in our busy center. Therefore, we have a few simple rules that we insist you follow:

1. Meet all your appointments. Arrange your activities so that this can occur.
2. If you become ill, please check with us by phone. We may still want you to arrive, because treatments may be able to help you.
3. If you are unable to make an appointment due to an emergency, please contact us by phone or email and let us know so we can reschedule your appointment.
4. With the exceptions of unexpected emergencies, we require that you notify us at least 24 hours in advance as to any appointment changes.
5. All cancelled/missed appointments should be rescheduled & made up within 1 week.
6. There is a $40 service charge for cancellations made with less than 24-hour notice or no call/no show appointments.

I have read, understand, and agree to follow the above policy.

Patient's Name: _____Signature: _____

HOLISTIC HEALTH
ASSOCIATES
603-B W. Patrick St Frederick MD 21701 301-620-1414

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS (HIPPA)

NAME _____ BIRTHDATE _____

Release of medical records: if during the course of my care, the office feels it necessary to send my medical records to another provider or associated company that is requesting them, I give my permission for release of said records.
I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:
X_____ _____
Patient Signature or Legal Representative Date

Office Use Only:
⎡ Accepted _____ _____ _____
⎣ Denied Signature Title Date

HOLISTIC HEALTH
ASSOCIATES

603-B W. Patrick St Frederick MD 21701 301-620-1414

INSURANCE INTAKE FORM

Provider: Ryan Diener / Priscilla Sullivan / Caitlin Toft / Ludwig Kragler / Frank Neely / KJ Sauer
Facility: Holistic Health Associates

Client Name:_____ Today's Date_____

Address:_____City_____ST_____Zip_____

Client Phone: (day)_____

DOB: _____Sex: M or F Marital Status: S M D W Full Time Student? Y or N

Employer: _____Full Time:___ Part Time:___ Position:_____

Primary Insurance: _____

Primary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number (on card): _____

Member ID# _____Group # _____

Secondary Insurance:

_____

Secondary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number: _____

Member ID# _____Group # _____

Please provide us with your insurance cards for claims filing.

My signature below authorizes:

1) **Provider to render treatment and apply for benefits.**
2) **Payment of medical benefits directly to the Provider.**
3) **The release of any medical or other information necessary to process this claim.**
4) **MEDICAL INSURANCE: We have contracts with BC/BS Carefirst, Cigna, and United Healthcare companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.**

Patient: _____Date:_____