

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):** phone: home, work, or cell 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Other (please list below)</u>			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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
Neuropsych	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
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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 _____

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 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

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 payor 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: _____

Signature

Date: _____

PATIENT MISSED APPOINTMENT POLICY

It's our wish that each & 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 \$20 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:** _____

**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:

Patient Signature or Legal Representative

Date

Witness Signature

Office Use Only:

detpeccA[†] _____

[†] Denied _____
Signature

Title

Date

INSURANCE INTAKE FORM

Provider: Ryan Diener// Todd McCloskey /Priscilla Sullivan / Caitlin Toft /Ludwig Kragler
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): _____

MemberID# _____ Group # _____

Secondary Insurance:

Secondary Insurance Holder's Name: _____ DOB: _____

Client's Relationship to Subscriber: _____

Insurance Phone Number: _____

MemberID# _____ 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:** _____