HOLISTIC HEALTH ASSOCIATES

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

Men's Confidential Health History – Nutrition Program

Please write or print clearly

Name: _____ Today's Date: _____

Address: _____

Telephone – Work: _____ Home: _____ Cell: _____

Email address: _____ How often do you check email? _____

Preferred means of contact: **(please indicate one):**

O phone call – home – work – cell O text message O email

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

How did you hear about us? _____ Other: _____

Referral-Who? _____ Internet-Which Search? _____Yellow Pages_____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationship status: _____

Children: _____ Pets: _____

Occupation: _____ Hours of work per week: _____

Please list your main health concerns: _____

_____

_____

Other concerns and/or goals? _____

_____

At what point in your life did you feel best? _____

Any serious illnesses/hospitalizations/injuries? _____

_____

How is the health of your father? _____

How is the health of your mother? _____

What is your ancestry? _____ What blood type are you? _____

Do you sleep well? _____ How many hours? _____ Do you wake up at night? _____

Why? _____

Any pain, stiffness or swelling? _____

Constipation/Diarrhea/Gas? _____ Explain: _____

Allergies or sensitivities? Please explain: _____

Do you take any supplements or medications? Please list: _____

_____

Any healers, helpers or therapies with which you are involved? Please list: _____

_____

What role does sports and exercise play in your life? _____

_____

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

What's your food like these days?

Breakfast	Lunch	Dinner	Snacks	Liquids

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? _____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

_____

What percentage of your food is home cooked? _____ Do you cook? _____

Where do you get the rest from? _____

The most important thing I should change about my diet to improve my health is: _____

Anything else you want to share? _____

_____

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Symptom Questionnaire

Initials:_____ Number # : _____ Visit # : _____ Date: _____

Rate each of the following symptoms based on the last year:

Point Scale	0 Never or almost never have the symptom	3 Frequently have it, effect is not severe
	1 Occasionally have it, effect is not severe	4 Frequently have it, effect is severe
	2 Occasionally have it, effect is severe	

Head ____Headaches ____ Faintness ____Dizziness ____Insomnia ____Total	Digestive ____Nausea, vomiting Tract ____Diarrhea ____Constipation ____Bloated feeling ____ Belching, passing gas ____Heartburn ____Intestinal / stomach pain ____Total
Eyes ____Watery or itchy eyes ____ Swollen, red or sticky eyelids ____Bags or dark circles under eyes ____ Blurred or tunnel vision (does not include near or farsightedness) ____Total	Joints/ ____Pain or aches in joints Muscle ____Arthritis ____ Stiff or limitation of movement ____ Pain or aches in muscles ____ Feeling of weakness or tired ____Total
Ears ____ Itchy ears ____ Earaches, ear infections ____ Drainage from ear ____ Ringing in ears, hearing loss ____Total	Weight ____Binge eating/drinking ____Craving certain foods ____Excessive weight ____Compulsive eating ____Water retention ____ Underweight ____Total
Nose ____ Stuffy Nose ____ Sinus problems ____ Hay fever ____ Sneezing attacks ____ Excessive mucus formation ____Total	Energy/ ____Fatigue, sluggishness Activity ____ Apathy, lethargy ____Hyperactivity ____ Restlessness ____Total
Mouth/____Chronic Coughing Throat ____Gagging / need to clear throat ____Sore throat, hoarse, loss of voice ____Swollen or discolored tongue, gums, or lips ____Canker sores ____Total	Mind ____Poor memory ____ Confusion, poor comprehension ____Poor concentration ____ Poor physical coordination ____Difficulty in making decisions ____ Stuttering or stammering ____ Slurred speech ____ Learning disabilities ____Total
Skin ____Acne ____Hives, rashes, dry skin ____Hair loss ____Flushing, hot flashes ____Excessive sweating ____Total	Emotions ____ Mood swings ____Anxiety, fear, nervousness ____ Anger, irritability, aggression ____ Depression ____Total
Heart ____Irregular or skipped heartbeat ____Rapid or pounding heartbeat ____ Chest pain ____Total	Other ____Frequent illness ____Frequent or urgent urination ____Genital itch or discharge ____Total
Lungs ____Chest congestion ____Asthma, bronchitis ____Shortness of breath ____Difficulty breathing ____Total	Grand Total _____

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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: _____

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

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 the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and will bill your insurance in a timely manner.
We currently accept Blue Cross Blue Shield, United, and Cigna health care. 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. If your policy identifies a % liability, we will bill you once the date of services has been processed by your carrier. Your full portion of the bill is expected to be when payment is received from your insurance carrier. 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 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. If a balance is due, payment will be applied to the outstanding balance first. Amount 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.
- If you change insurance companies or employers, you agree to provide this office with the current information immediately.

If this office gives you any professional 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: _____ **Date:**_____
Signature

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 or no call/no show appointments.

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

Patient's Name: _____**Signature:** _____

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

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 Witness Signature

Office Use Only:
☐ Accepted _____ _____ _____
☐ Denied Signature Title Date