Acupuncture New Patient Paperwork

Advanced Wellness Centre

Date:_____ Patient Name:_____

Street:_____City:_____State:____Zip:_____

Home Phone:_____ Work Phone: _____

Email Address: _____

Age:_____ Height:_____ Weight:_____ Date of Birth:_____

Place of Birth:_____ Social Security Number:_____

Occupation:_____ Partner Status:_____

In Case of Emergency Notify: _____

Relation:_____ Phone Number:_____

Family Physician:_____

Concurrent Health Therapies or Regimens:_____

How did you hear about our clinic? Or who referred you?

- ☐ Family Member
- ☐ Employer
- ☐ Print Ad
- ☐ Returning Patient
- ☐ Friend
- ☐ Event
- ☐ Sign on Building
- ☐ TV Commercial
- ☐ Physician
- ☐ Insurance Website
- ☐ Internet Web Site
- ☐ Radio
- ☐ Health Class
- ☐ Brochure
- ☐ Direct Mail Ad
- ☐ Other

If you selected family member/friend/physician please list their name here:_____

If you selected internet website/event or other please describe:_____

FAMILY MEDICAL HISTORY:

- ☐ Allergies
- ☐ Diabetes
- ☐ Asthma
- ☐ Cancer
- ☐ Stroke, Heart Disease
- ☐ High Blood Pressure
- ☐ Seizures
- ☐ Alcoholism
- ☐ Other:_____

PAST MEDICAL HISTORY (WITH DATES):

- ☐ Allergies
- ☐ Seizures
- ☐ Vaccinations
- ☐ Cancer
- ☐ Surgeries
- ☐ Childhood Illnesses
- ☐ Seizures
- ☐ Heart Disease
- ☐ Other Significant Illnesses
- ☐ Hepatitis
- ☐ Venereal Disease
- ☐ Accidents or trauma
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Birth Trauma

PHYSICAL TRAMAS

Have you been in an accident? If so, please specify the date and nature of the accident(s):_____

_____

_____

_____

Please list any surgeries, with dates, that you have had:_____

_____

_____

_____

LIFESTYLE & OCCUPATION:

Exercise:_____

Dietary Considerations:_____

Habitual Consumptions: ☐ Cigarettes ☐ Coffee, Tea or Cola ☐ Alcoholic Beverages ☐ Other

Occupational Stress Factors:_____

Medications taken within the last two months (vitamins, drugs, herbs, etc):_____

_____

_____

_____

CURRENT GENERAL HEALTH INDICATORS:

☐ Poor Appetite	☐ Heavy Appetite	☐ Changes in appetite
☐ Disturbed Sleep	☐ Heavy Sleep	☐ Insomnia
☐ Fatigue	☐ Localized Weakness	☐ Sweating easily
☐ Poor Coordination	☐ Strong Thirst	☐ Cravings
☐ Weight Gain	☐ Weight Loss	☐ Change in Appetite
☐ Cold Hands	☐ Cold Feet	☐ Cold Back
☐ Night Sweats	☐ Fevers	☐ Chills
☐ Cold Abdomen	☐ Poor Balance	☐ Sensitive to tastes or smells
☐ Tremors	☐ Bleeding or Bruising Easily	☐ Sudden energy drop (when?)

☐ Other Unusual or Abnormal Conditions:_____

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives
☐ Itching	☐ Eczema	☐ Pimples
☐ Dandruff	☐ Hair Loss	☐ Recent Moles
☐ Purpura	☐ Change in Hair or Skin Texture	

☐ Any Other Hair or Skin Problems:_____

HEAD AND NECK

☐ Dizziness	☐ Concussions	☐ Migraines
☐ Glasses	☐ Spots in Front of Eye	☐ Headaches (Where? When?)
☐ Eye Pain	☐ Poor Vision	☐ Night Blindness
☐ Color Blindness	☐ Cataracts	☐ Blurry Vision
☐ Eyestrain	☐ Spots in Eyes	☐ Ringing in Ears
☐ Poor Hearing	☐ Earaches	☐ Mucus
☐ Dry Throat	☐ Dry Mouth	☐ Copious saliva
☐ Sinus Problems	☐ Recurrent Sore Throats	☐ Nose Bleeds
☐ Grinding Teeth	☐ Sores on Lips or Tongue	☐ Facial Pain
☐ Teeth Problems	☐ Gum Problems	☐ Jaw Clicks

☐ Any other head or neck problems:_____

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Cold Hands or Feet
- ☐ Swelling of Hands
- ☐ Swelling of Feet
- ☐ Blood Clots
- ☐ Difficulty in Breathing
- ☐ Phlebitis
- ☐ Any Other Heart or Blood Vessel Problems:_____

RESPIRATORY

- ☐ Cough
- ☐ Pain with deep inhalation
- ☐ Difficulty breathing when lying down
- ☐ Bronchitis
- ☐ Production of Phlegm (color?)
- ☐ Pneumonia
- ☐ Coughing up blood
- ☐ Asthma
- ☐ Any Other Lung Problems:_____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black Stools
- ☐ Blood in Stools
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic Laxative Use
- ☐ Sensitive Abdomen
- ☐ Any Other GI Problems:_____

GENITOURINARY

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urgency to Urinate
- ☐ Unable to hold Urine
- ☐ Kidney Stones
- ☐ Decrease in Work Flow
- ☐ Impotence
- ☐ Sores on Genitals
- ☐ Waking at Night to Urinate
- ☐ Any Particular Color to Urine
- ☐ Any Other Problems with Genitourinary Function:_____

REPRODUCTIVE AND GYNECOLOGIC

- ☐ Age at Menarche _____
- ☐ Age at Menopause _____
- ☐ Birth Control Method (since_____)
- ☐ Number of Live Births _____
- ☐ Premature Births _____
- ☐ Number of Pregnancies _____
- ☐ Menstrual Clots
- ☐ Painful Menses
- ☐ Miscarriages/Abortions_____
- ☐ Strong Menstrual Odor
- ☐ Duration of Menses_____
- ☐ Vaginal Odor
- ☐ Vaginal Discharge
- ☐ Irregular Menses
- ☐ Breast Lumps or Swelling
- ☐ Premenstrual Changes
- ☐ Other Problems:_____
- ☐ Other Menstrual Problems:_____

MUSCULOSKELETAL

- ☐ Neck Pain
- ☐ Muscle Pains
- ☐ Knee Pain
- ☐ Back Pain
- ☐ Muscle Weakness
- ☐ Foot/Ankle Pains
- ☐ Hand/Wrist Pains
- ☐ Shoulder Pains
- ☐ Hip Pain
- ☐ Any Other Joint or Bone Problems:_____

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

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

- Personal health information including clinical records may be disclosed to another health care provider or hospital as a means of communication about and coordination of your care.
- Billing and health care records may be disclosed to another party, if they are or may be responsible for payment of your services.
- As a means by which a third party can verify that services billed were actually provided.
- As a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.
- Your name, address, phone numbers 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 at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- 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

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

_____

I state that my health information can be released to the following family members or persons:

_____

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive care from us. We may also mail or email 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 different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

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. We 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.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to the Office Manager. This notice is effective as of April 15, 2003. 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

If you are a minor, or if you are being represented by another party:

_____	_____	_____
Personal Representative (please print)	Personal Representative Signature	Date

_____

Description of the authority to act on behalf of the patient.

Medical Services Contract

I hereby authorize **Advanced Wellness Centre, PC** to render medical services to me (or child) and to release any information regarding my medical history, diagnosis and treatment of myself (or child, if applicable) to my insurance company regarding my claim for chiropractic and physical therapy benefits and to my (or child's) primary care physician. I authorize payment directly to **Advanced Wellness Centre, PC** for the benefit otherwise payable to me under the terms of my insurance. I understand that **Advanced Wellness Centre, PC** will file my insurance; however, if the insurance company payments are not timely, it is my responsibility to pay **Advanced Wellness Centre, PC** and pursue my recovery with the insurance carrier. Advanced Wellness Centre,PC will verify your insurance benefits as a courtesy. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service. I understand that I am financially responsible for all changes arising from chiropractic and physical therapy treatment, which are separate services and may have separate co-pays and/or coinsurance.

I understand that if my insurance company requires a referral for treatment that I am responsible for obtaining that referral. I agree that if I did not obtain that referral and I receive treatment without the referral, I am fully financially responsible for any services denied for no referral. I understand that I am also responsible for court testimony, medical reports, and any other charges arising from said treatment if necessary. There will be a one time initial X-ray interpretation fee per X-ray series/region, your X-rays will be sent to a medical radiologist for an overread. I understand that it will not be filed to my insurance and I am responsible for this fee.

Our goal is to provide quality care in a timely manner to all of our patients. In order to accomplish this we have instated a cancellation/no show policy. We require that you cancel your appointment with 24 hour notice. Appointments are in demand and this enables another patient to receive timely care. If 24 hour notice is not given, this will be considered a no show. No shows are an inconvenience to those trying to receive care. **A $45.00 fee will be charged to all patients that fail to show for their appointments.** Three consecutive no show/cancellation appointments may result in an automatic discharge for the patient.

I hereby further assign the causes of action I have to said doctor on any and all proceeds of any medical payment, insurance benefits and (if applicable) on any settlement or judgement form the injuries for which I have been treated.

If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees in the amount of thirty-three point three percent (33.3%) of the total indebtedness and court costs incurred by **Advanced Wellness Centre, PC**. If this indebtedness is not paid in full within sixty days, I agree to pay a service charge of one and one-half percent (1 1/2 %) per month, eighteen percent (18%) per annum.

Responsible Party/Patient's Signature:_____

Your name:_____ Date:_____

(please print)

Advanced Wellness Centre
Acupuncture

I hereby authorize any person(s) that is serving under the supervision of my health care provider to be present during all phases of my patient analysis and treatment for observational and assistance purposes.

I understand that any assistant or intern of an Advanced Wellness Centre health care provider, that bears witness to any part of my personal information, is bound by the same laws and expectations of patient confidentiality and responsibility as the healthcare provider him/herself.

Signature: _____

Printed Name: _____

DOB: _____

Date Signed: _____

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