Whole Healing Acupuncture, LLC

PATIENT REGISTRATION FORM

NAME _____ DATE OF BIRTH_____
First Middle Last
SEX: ○M ○F
MARITAL STATUS_____

ADDRESS _____
Street City State Zip

HOME # _____ WORK#_____ CELL#_____

E-MAIL _____ OCCUPATION_____

Preferred method to contact you: ☐ E-Mail ☐ Home ☐ Work ☐Cell

Who should we contact in an emergency? _____ Relationship _____Ph#_____

Who can I thank for referring you? _____

PRIMARY INSURANCE COMPANY

Company Name_____
Policy # _____
Group # _____
Policy Holder Name : _____
Policy Holder Birth Date: _____
Relationship to you: _____

SECONDARY INSURANCE COMPANY

Company Name_____
Policy # _____
Group # _____
Policy Holder Name : _____
Policy Holder Birth Date: _____
Relationship to you: _____

Do I have your permission to:

Leave a message on your answering machine at home? ☐ Yes ☐ No
Leave a message at your place of employment/ work voice mail? ☐ Yes ☐ No
Send you a message via email or text? ☐ Yes ☐ No
Discuss your medical condition with any member of your household/family? ☐ Yes ☐ No
Who may I disclose your health information to? _____

_____

ASSIGNMENT OF BENEFITS / INFORMATION RELEASE / AUTHORIZATION TO TREAT

I authorize payment of medical benefits to Whole Healing Acupuncture, LLC for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance. **Charges and co-pays are due at the time of service. A fee of $80.00 may be assessed for a missed appointment or late cancellation (less than 24 hrs).** If my account is turned over to a collection agency, I will be responsible for all collection fees incurred. I authorize you to release to my insurance company, PIP, other payer or any of their agents, and attorneys (as applicable) any information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purposes of evaluating and administering claims of benefits.

I have been given the opportunity to review your Notice of Privacy and Disclosure Practices.

_____ _____
Signature of Patient, Parent or Guardian (if patient is under age 18) Date

Whole Healing Acupuncture, LLC

MEDICAL HISTORY

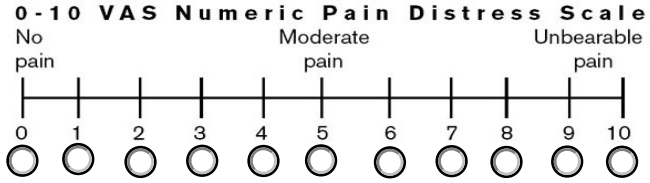
Name: _____ **DOB_____**

The reason(s) you are here: _____

Date of Injury/Onset: _____ Is this a work injury? _____ Is this a result of a motor vehicle accident? _____

Is the injury/accident the fault of another party? _____

Please mark below your level of pain at its worst:



Have you received any of the following? (Please check all that apply):

- ☐ X-Rays
- ☐ Bone Scan
- ☐ MRI
- ☐ Chiropractic
- ☐ CT Scan
- ☐ Massage Therapy
- ☐ Injections
- ☐ Physical Therapy
- ☐ Nerve Blocks
- ☐ Acupuncture
- ☐ Other _____

Please list any surgeries and/or hospitalizations:

Date(s)	Surgery / Illness
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a history of any of the following? (Please check all that apply):

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer _____
- ☐ Stroke
- ☐ Shortness of Breath
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Chest Pain
- ☐ Metal Implants
- ☐ Hypoglycemia
- ☐ Allergies _____
- ☐ Diabetes
- ☐ Other _____

Please list any prescription drugs, over the counter medicines, herbs or supplements are you taking?

Drug / Supplement Name	For what condition?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Personal Lifestyle Habits: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) _____

Coffee / Tea (cups) _____

Alcohol (drinks per week) _____

Illicit Drugs: _____

For the following, please put a **"C"** if the condition is current or a **"P"** if you had it in the past.

General
__ Insomnia
__ Dreams / nightmares
__ Fatigue
__ Poor memory
__ Strong desire for cold drinks
__ Strong desire for hot drinks
__ Significant weight loss/gain
__ Cold hands & feet
__ Chills
__ Fever

Head & Neck
__ Headaches
__ Migraines
__ Stiff Neck
__ Dizziness
__ Fainting
__ Swollen glands

Ears
__ Ringing
__ Hearing loss
__ Hearing aides
__ Infections
__ Earache
__ Vertigo

Eyes
__ Glasses/ contact lenses
__ Blurred vision
__ Poor night vision
__ Spots or floaters
__ Eye inflammation
__ Dry eyes
__ Double vision
__ Glaucoma
__ Cataracts

Nose, Throat, & Mouth
__ Sinus infection
__ Hay fever / allergies
__ Frequent sore throat
__ Difficulty swallowing
__ Mouth & tongue ulcers
__ Frequent colds
__ Nosebleeds
__ Dry nose
__ Nasal congestion
__ Loss of voice
__ Thirst
__ Excessive phlegm
__ TMJ pain/dysfunction
__ Facial pain
__ Gum problems
__ Dry mouth

Skin
__ Hives
__ Rashes
__ Eczema
__ Psoriasis
__ Excess sweating
__ Night sweating
__ Dry skin
__ Easily bruised
__ Changes in moles, lumps
__ Itching

Respiratory
__ Difficulty breathing
__ Difficulty breathing, reclined
__ Wheezing
__ Asthma
__ Chronic cough
__ Wet cough
__ Coughing up phlegm
__ Coughing up blood
__ Shortness of breath
__ Tight chest
__ Pneumonia

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ Chest pain or tightness
__ Palpitation
__ Rapid heart beat
__ Irregular heart beat
__ Swollen ankles
__ Phlebitis
__ Anemia
__ Heart attack
__ Stroke

Gastrointestinal
__ Nausea
__ Indigestion
__ Stomach pain
__ Diarrhea
__ Constipation
__ Poor appetite
__ Excessive hunger
__ Vomiting
__ Gas
__ Hiccups
__ Acid reflux
__ Bloating
__ Bad breath
__ Laxative use
__ Bloody stool
__ Hemorrhoids

Musculoskeletal
__ Joint pain/ arthritis
__ Sore muscles
__ Weak muscles
__ Difficulty walking
__ Neck/shoulder pain
__ Upper back pain
__ Lower back pain
__ Rib pain
__ Other _____

Urinary
__ Pain with urination
__ Frequent urination
__ Urgency
__ Blood in urine
__ Incontinence/ leaking
__ Incomplete urination
__ Bedwetting
__ Wake to urinate
__ Kidney stones
__ Bladder / urinary infections

Neurological
__ Seizures
__ Tremors
__ Numbness or tingling
__ Paralysis
__ Poor coordination
__ Loss of balance
__ Other _____

Mental / Emotional
__ Depression
__ Mood swings
__ Irritability
__ Difficulty relaxing
__ Loneliness
__ Sensitive
__ Shy
__ Cry often
__ Worry often
__ Compulsive behaviors
__ Difficulty concentrating
__ Hopeless outlook
__ Suicidal thoughts
__ Lose temper
__ Frustration

Male Genital / Sexual
__ Impotence
__ Premature ejaculation
__ Nocturnal emission
__ Pain / itching of genitalia
__ Lumps in testicles
__ Increased libido
__ Low libido

Gynecology / Female Sexual
__ Pregnant
__ # of pregnancies
__ Miscarriage
__ Abortion
__ Menopause
__ Hormone Replacement
__ Irregular Periods
__ Menstrual Cramps
__ Breast tenderness
__ Breast lumps, cysts
__ Abnormal pap smear
__ Vaginal infections
__ Vaginal pain/ itching
__ Excessive vaginal discharge
__ Yeast infections
__ Uterine fibroids
__ Ovarian cysts
__ Endometriosis
__ PMS
__ Increased libido
__ Low libido

Signature _____ Date_____

Whole Healing Acupuncture, LLC
Arianna Z. Berkowitz, LAc, MPT
443-745-1560

Consent to Treatment

I voluntarily consent to be treated with acupuncture, aromatherapy, and /or manual therapy. It is important that I be aware of the following points:

1. I understand that I may be treated with the insertion of acupuncture needles, the application of heat to the skin (moxabustion), the use of light touch to the body, the use of essential oils to the body , and dietary and physical recommendations as deemed appropriate by my practitioner.

2. Acupuncture may occasionally result in local bruising, slight bleeding, fainting, temporary pain or discomfort, or temporary aggravation of symptoms existing prior to treatment.

3. If my ailment or condition should worsen, or if a new ailment should appear, I should consult my physician or any other licensed physician.

4. I have not been guaranteed any success concerning the uses and affects of acupuncture, aromatherapy or Bowenwork. I understand that I am free to discontinue treatment at any time.

5. Confidentiality will be preserved at all times. Contact with other health professionals will only be made with my written consent.

6. I understand that my appointment time is a reserved time for me. If I cancel, miss, or change my appointment without at least twenty-four hour notice, I will be charged a full treatment fee for this time. This does not apply to an emergency situation or a last-minute cancellation due to inclement weather. I understand that my practitioner's ability to serve other clients and me is dependent upon my cooperation with this cancellation policy. _____

7. I understand that payment is expected at the time of treatment. I also understand that it is my responsibility to be aware of what is covered under my insurance policy.

8. I understand that treatment is a cooperative process, and will endeavor to take responsibility for my own healing by asking questions regarding this process and following the suggestions of my practitioner.

I acknowledge having read and understood the above points concerning my treatment. I have felt free to ask any questions and the process has be satisfactorily explained to me.

Client's Name (please print) _____

Signature (client or guardian) _____

Date: _____

Whole Healing Acupuncture, LLC

NOTICE OF PRIVACY & DISCLOSURE PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR HEALTH INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY. The law requires that we maintain the privacy of your medical information. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. We reserve the right to make changes to our practices and this notice, and we promise to make a good faith effort to notify you of any changes.

Your health information will be routinely used for treatment, consultation, payment and quality monitoring, and your consent or the opportunity to object or agree is not required in these instances. Your medical information may be shared with others involved in your care or providing consultation about your treatment. We may use and disclose your medical information to your insurance plan or third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions and procedures performed. Your information may be reviewed for risk management or quality improvement purposes. You have the right to restrict certain disclosures of your private health information (PHI) to Medicare or any other payer related to services that you have paid for out of pocket.

We may, as part of routine practice, use and disclose some or all of your health information to family members, a close personal friend identified by you, or other personal representative in order to schedule or confirm appointments, or to assist them in enhancing your well-being or to confirm your whereabouts. You have the right to request restrictions on these uses. You can revoke an authorization at any time by notifying our office in writing. You have the right to opt out of using your PHI for marketing or fundraising efforts. The sale of your PHI is prohibited without your consent.

Additional disclosures are required by law and do not require your consent. These include: the disclosure of health information to the **FDA** related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements; the release of health information to **worker's compensation** to the extent authorized by law; the disclosure of health information to **public health** and or legal authorities to avert a serious threat to public health or safety, to report communicable disease, injury, or disability or to comply with mandated reporting requirements for tracking of birth and morbidity; and the disclosure of your health information as required under state and federal law to the appropriate **law enforcement officials, public health authorities, and/or attorneys**: (1) in response to a valid subpoena, (2) in the event of suspected unlawful conduct of a practitioner or violations of professional standards; (3) when a patient is the suspected victim of abuse, neglect or domestic violence.

Your health record is the property of Whole Healing Acupuncture, LLC, but the content is about you, and therefore belongs to you. **You have the right to review and receive a paper or electronic copy of your health information, and to request that appropriate amendments/approved corrections be made to your health record. You have the right to request restrictions on the uses and disclosures of your health record, and the right to be given an account of those disclosures. You have the right to receive confidential communications and to request communication by alternate means or to alternate locations should we need to contact you.**

If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office. Office for Civil Rights Hotline: 1-800-368-1019

I hereby acknowledge my receipt and understanding of the ***Notice of Privacy Practices.***

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Date