Patient Information Sheet

CONFIDENTIAL

5191 S. Yosemite, Suite B Greenwood Village, CO 80111 Phone: (303) 577-9977 www.integrativehealthinc.com

Important: Complete this document as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date _____ / _____ / _____	First Name	Last Name	Social Security Number — —
Gender **M F**	Date of Birth _____ / _____ / _____	Age	Marital Status **Single Married Separated Divorced**
Street Address	City	State	Zip

Phone (Daytime) – **Home Work Mobile** *Circle One* ( )	Alternate Phone # – **Home Work Mobile** *Circle One* ( )
Place of Employment -- Occupation ------------------------	Phone Numbers of Emergency Contact Primary ( ) Alternate ( )

Circle Insurance Coverage (Please circle one)

None Workers' Comp Auto Injury Health Insurance Company__________________________

E-Mail:

How did you hear about us? *Please circle one and write the name*

Current Patient: __________ Doctor: __________Advertisement: __________ Friend: ________Insurance: ___________ Other: ____________

Chief complaint: ____

How long? ________________________________ How often: ______________________________

What caused this (accident, lifestyle, drug, etc.)? ______________________________

Describe the worst it can be: ______________________________________

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? __________________

Get temporary relief? _______ Fixes problem? _______ Causes side effects? _______

How does this affect your life? ______________________________________

Affect your family? ______________________________ Affect your sleep? __________________________

Affect your work? ______________________________ Affect your hobbies? __________________________

What is your goal/plan if the problem continues 5/10/20 years? ______________________________

Complaint #2: ____

How long? ________________________________ How often: ______________________________

What caused this (accident, lifestyle, drug, etc.)? ______________________________

Describe the worst it can be: ______________________________________

What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? __________________

Get temporary relief? _______ Fixes problem? _______ Causes side effects? _______

How does this affect your life? ______________________________________

Affect your family? ______________________________ Affect your sleep? __________________________

Affect your work? ______________________________ Affect your hobbies? __________________________

What is your goal/plan if the problem continues 5/10/20 years? ______________________________

Other Complaints:

3) ______________________________________ 4) ______________________________________

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better__________
Have you had acupuncture before? ___________
If yes, where/who ________________________
Any concerns or fears about the needles? ______
If yes, what? __________________________
What are your goals of your acupuncture visits?
1. ________________________________
2. ________________________________
3. ________________________________

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – **NOTE**: **For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.**

LIVER / GALLBLADDER
______ Irritability / Anger
______ Depression / Stress
______ Headaches / Migraines
______ Visual Problems
______ Red / Dry / Itchy Eyes
______ Gall Stones
______ Dizziness
______ Blurred Vision
______ Feeling of Lump in Throat
______ Clenching of Teeth at Night
______ Muscle Cramping / Twitching
______ Tension
______ Joints/Neck/Shoulder Pain/Tight
______ Poor Circulation
______ Soft / Brittle Nails
______ Emotional Eater

KIDNEY / URINARY BLADDER
______ Urinary Problems
______ Bladder Infection
______ Lack of Bladder Control
______ Weakness / Pain in Lower Back
______ Decrease Bone Density
______ Feel Cold Easily
______ Low Sex Drive
______ Excess Sexual Desire
______ Poor Memory
______ Loss of Hair
______ Hearing Problems
______ Cavities
______ Craving / Avoiding Salty Foods
______ Fear
______ Hot Flush / Night Sweating

HEART / SMALL INTESTINES
______ Heart Palpitations
______ Chest Pain
______ Insomnia / Sleep Problems
______ Easily Startled
______ Restlessness / Agitation
______ Vivid Dreams
______ Lack of Joy in Life

LUNG / LARGE INTESTINE
______ Dry Cough
______ Cough with Sputum
______ Nasal Discharge
______ Post-Nasal Drip
______ Sinus Infection / Congestion
______ Itchy, Red or Painful Throat
______ Dry Mouth / Throat / Nose
______ Skin Rashes / Hives
______ Snoring
______ Grief / Sadness
______ Shortness of Breath
______ Allergies / Asthma
______ Low Resistance to Colds or Flu
______ Sneezing
______ Mild Fever Comes & Goes
______ Smoke Cigarettes

SPLEEN / STOMACH
______ Heaviness Anywhere in Body
______ Fatigue / Worse After Eating
______ Hard to Get Up in the Morning
______ Edema (Swelling)
______ Muscles Feel Tired Often
______ Easily Bruising & Bleeding
______ Bad Breath
______ Decreased / Increased Appetite
______ Crave Sweets
______ Hypoglycemia
______ Difficulty Digesting Oily Foods
______ Nausea / Vomiting
______ Gas / Belching
______ Insulin Sensitivity
______ Hemorrhoids
______ Constipation
______ Diarrhea
______ Abdominal Pain
______ Indigestion / Heartburn
______ Over-Thinking
______ Tendency to Gain Weight
______ Brain Foggy

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate health problems for yourself and your family members under the appropriate columns with a “**C**” for current issues, “**P**” should be used to indicate a past problem. Leave blank those that do not apply.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_______________											
Other:__________________											

If any of the above family members are deceased, please list their age at death and cause.

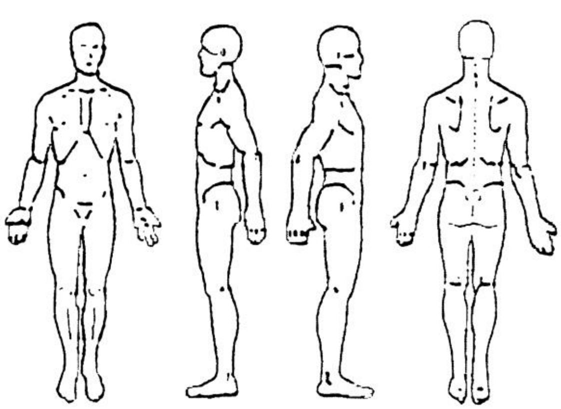
____

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:____________________

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No

Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period end? _______________

Number of days for monthly cycle? _______________

Number of days bleeding lasts? _______________

Describe Menstrual Flow:

☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:

☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:

☐ None ☐ IUD ☐ Birth Control Pills

☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*

- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*

- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility

☐ Pelvic Inflam. Disease ☐ Ovarian Cysts

☐ Endometriosis ☐ Hot Flashes

☐ Mastitis ☐ Breast Cysts

☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*

- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection

☐ Discharge from Penis ☐ Prostate Problems

☐ Testicular Pain or Lump ☐ Infertility

☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Diary: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

____

____

____

____

____

____

Thank you for completing this form. Your time is greatly appreciated and we value this opportunity to serve you!

INTEGRATIVE HEALTH, INC.
WELLNESS CENTER
EXPERTS PROVIDING NATURAL HEALTHCARE

I, ________________ understand Integrative Health Wellness Center is a wellness building that houses a variety of health professional businesses. As a patient you realize you are not being treated by Integrative Health Inc., but the specific provider you are seen by and their business. Integrative Health is not your health care provider and cannot be held responsible for any harm or damages to your person.

By signing this form you understand the stated fact and release Integrative Health Inc. from any damages that could occur to my person.

____
Print Full Name

____ Date__________________
Signature

PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. HEALTHCARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENT, HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THE FOLLOWING ALSO OUTLINES HOW YOU CAN ACCESS YOUR HEALTH CARE INFORMATION.

PLEASE READ THE FOLLOWING CAREFULLY AND SIGN BELOW.

As your healthcare provider, I use your health information for evaluation, treatment, to obtain payment for treatment and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, electronic mail, fax or other methods.
We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time.

If at any time we change our policies in regard to your medical information, you will be informed with a new "Notice of Privacy Practices" form and will be asked to sign it.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information if corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Integrative Health, Inc. at 303-577-9977, or you can file a written complaint with the U.S. Department of Health and Human Services. Integrative Health, Inc. is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Integrative Health, Inc. to release any information required to process this claim to any insurance company or attorney in this case. I also authorized any insurance company or medical provider to release my medical records to Integrative Health, Inc. This information is to be used for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original copy.

PAYMENT AGREEMENT

I hereby authorize my insurance benefits to be paid directly to my provider I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by my provider. I must pay charges and services not covered by any insurance or other third-party payer and/or not paid to my provider for any reason within a time period my provider deems reasonable. The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator or third-party responsible for payment of the charges.

CANCELLATION NOTICE

Kindly give a 24 hour notice of cancellation. Late cancellations are subject to a cancellation fee.

Patient’s Name (Print): ____

Signature: ____ Date Signed: _______________

Colorado Mandatory Disclosure and Consent Form for Acupuncture

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body, by well-trained, licensed acupuncturists. Acupressure, acupuncture, moxibustion, cupping, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis or treatment of any disease or injury.

I understand that complications may result from acupuncture treatment. Among these possible complications are areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia, or coumadin use. Please use caution walking with bare feet in the treatment room. I, the patient, further understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

We gladly accept automotive, worker's compensation, and major medical insurance as payment. Insurance coverage depends on your plan. Please call your insurance company ahead of time to find out what your acupuncture benefits are.

<u>Colorado law requires all acupuncturists provide the following information to clients on their first visit</u>:

<u>Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations</u>:
Your provider has been licensed by the state of Colorado, which requires that they graduate from an approved institution (a four year program), and pass the National Board Exam (NCCAOM) for acupuncture and oriental medicine. They have never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

<u>Cash Fee Schedule</u>:		<u>Insurance Fee Schedule</u>:
Initial Acupuncture Treatment (incl. exam)……………..	$150.00	Based on benefit coverage & allowed amount determined by the insurance company.
Follow-up Acupuncture Treatment……………………...	$95.00	
5-visit Family Plan………………………………………	$450.00	
10-visit Family Plan……………………………………..	$850.00	
Membership (1 yr)……………………………………..	$80/ follow-up ($960/year)	

All fees are due on the date of service, prices subject to change. Family plan refunds: total paid less $95 per treatment received. There are no expiration dates on family plans. See contract for Membership details. Any questions about billing should be discussed with your provider.

This office complies with all rules and regulations promulgated by the Colorado Department of Health related to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of acupuncture offices. This office uses only single-use disposable needles, and disposes of them in a manner consistent with OSHA and Colorado State regulations. We are trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

In a professional relationship sexual intimacy is never appropriate and should be reported to the Director of the Divisions of Registrations in the Department of Regulatory Agencies: The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. Send inquiries to the attention of: Director of the Division of Registrations 1560 Broadway, Suite 1545 Denver, CO 80202. Phone: (303) 894-2464. Each patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. If you have any questions about any part of your treatments, billing statements, etc., please ask the office manager and tell your provider.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): ____

____ ________________

Signature of patient or legal guardian **Date Signed**

Integrative Health Inc
Experts Providing Healthcare

5191 S Yosemite St, Suite B
Greenwood Village, CO 80111
Phone: 303-577-9977
www.IntegrativeHealthInc.com

INSURANCE BILLING INFORMATION

Dealing with insurance can be a complicated and confusing process. This information is meant to clear up any questions you might have when we are billing your insurance.

Each provider is their own independent business and therefore contracts individually with insurance. Confirm with your insurance or our front desk staff to see which providers are in-network and out-of-network with your insurance. Not all services are eligible under insurance.

The process to verify and bill insurance takes a few steps:

1. We will copy your insurance card, call and verify your benefits. We will find out if there is a deductible to be met prior to your insurance paying, or if you have a copay or coinsurance. To speed-up the verification process, contact your insurance prior to your appointment and we will honor benefits. Verification is never a guarantee of benefits. Your insurance will determine coverage upon receiving the claims.
2. When billing insurance, your provider will use specific legal codes designated to the service you received. These procedure codes, or CPT codes, have an assigned amount of time and fee attached to each. We must abide by these codes and they cannot be changed. The codes dictate the overall price at which the insurance company is charged, which is usually higher than the amount paid at time of service.
3. Once the insurance company receives the claim they will allow the full or a portion of the amount billed. For example, if the insurance company gets a bill for $250.00 they may decide to allow $60.00 or deny the claim. Usually a denial is based on a variety of reasons, when possible we submit corrected claims for approval. Insurance companies ask us to allow 60-90 days to process claims.
4. If your insurance benefits state that your insurance will only cover a percentage of the charges, you may be responsible for paying the difference.
5. We will do everything we can to get your claims processed and approved, however, if insurance does not pay for your service(s), you will be responsible for the billed amount. To avoid additional charges, payment must be made in a timely manner.

Your understanding of this process is critical in our working relationship of provider and patient. Thank you for taking the time to read this letter, for further questions please inquire at our front desk.

Patient's Name (Print): ____

____ ________________

Signature of patient or legal guardian **Date Signed**