

Patient Information Sheet

CONFIDENTIAL

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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.

Form with fields for Date, First Name, Last Name, Social Security Number, Gender, Date of Birth, Age, Marital Status, Street Address, City, State, Zip, Phone (Daytime), Alternate Phone #, Place of Employment, Occupation, Phone Numbers of Emergency Contact, Circle Insurance Coverage, E-Mail, and How did you hear about us?

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)

<p>On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better _____</p> <p>Have you had acupuncture before? _____</p> <p>If yes, where/who _____</p> <p>Any concerns or fears about the needles? _____</p> <p>If yes, what? _____</p> <p>What are your goals of your acupuncture visits?</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 	<p><u>MEDICAL CONDITIONS</u> Please List conditions & surgeries you have had and year diagnosed.</p> <table border="1" style="width: 100%; height: 100%;"> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> </table>									<p><u>ALLERGIES</u> Medications, Seasonal, Environmental, Food.</p> <table border="1" style="width: 100%; height: 100%;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>				

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.

<p><i>LIVER / GALLBLADDER</i></p> <p>_____ Irritability / Anger</p> <p>_____ Depression / Stress</p> <p>_____ Headaches / Migraines</p> <p>_____ Visual Problems</p> <p>_____ Red / Dry / Itchy Eyes</p> <p>_____ Gall Stones</p> <p>_____ Dizziness</p> <p>_____ Blurred Vision</p> <p>_____ Feeling of Lump in Throat</p> <p>_____ Clenching of Teeth at Night</p> <p>_____ Muscle Cramping / Twitching</p> <p>_____ Tension</p> <p>_____ Joints/Neck/Shoulder Pain/Tight</p> <p>_____ Poor Circulation</p> <p>_____ Soft / Brittle Nails</p> <p>_____ Emotional Eater</p> <p><i>KIDNEY / URINARY BLADDER</i></p> <p>_____ Urinary Problems</p> <p>_____ Bladder Infection</p> <p>_____ Lack of Bladder Control</p> <p>_____ Weakness / Pain in Lower Back</p> <p>_____ Decrease Bone Density</p> <p>_____ Feel Cold Easily</p> <p>_____ Low Sex Drive</p> <p>_____ Excess Sexual Desire</p> <p>_____ Poor Memory</p> <p>_____ Loss of Hair</p> <p>_____ Hearing Problems</p> <p>_____ Cavities</p> <p>_____ Craving / Avoiding Salty Foods</p> <p>_____ Fear</p> <p>_____ Hot Flush / Night Sweating</p>	<p><i>HEART / SMALL INTESTINES</i></p> <p>_____ Heart Palpitations</p> <p>_____ Chest Pain</p> <p>_____ Insomnia / Sleep Problems</p> <p>_____ Easily Startled</p> <p>_____ Restlessness / Agitation</p> <p>_____ Vivid Dreams</p> <p>_____ Lack of Joy in Life</p> <p><i>LUNG / LARGE INTESTINE</i></p> <p>_____ Dry Cough</p> <p>_____ Cough with Sputum</p> <p>_____ Nasal Discharge</p> <p>_____ Post-Nasal Drip</p> <p>_____ Sinus Infection / Congestion</p> <p>_____ Itchy, Red or Painful Throat</p> <p>_____ Dry Mouth / Throat / Nose</p> <p>_____ Skin Rashes / Hives</p> <p>_____ Snoring</p> <p>_____ Grief / Sadness</p> <p>_____ Shortness of Breath</p> <p>_____ Allergies / Asthma</p> <p>_____ Low Resistance to Colds or Flu</p> <p>_____ Sneezing</p> <p>_____ Mild Fever Comes & Goes</p> <p>_____ Smoke Cigarettes</p>	<p><i>SPLEEN / STOMACH</i></p> <p>_____ Heaviness Anywhere in Body</p> <p>_____ Fatigue / Worse After Eating</p> <p>_____ Hard to Get Up in the Morning</p> <p>_____ Edema (Swelling)</p> <p>_____ Muscles Feel Tired Often</p> <p>_____ Easily Bruising & Bleeding</p> <p>_____ Bad Breath</p> <p>_____ Decreased / Increased Appetite</p> <p>_____ Crave Sweets</p> <p>_____ Hypoglycemia</p> <p>_____ Difficulty Digesting Oily Foods</p> <p>_____ Nausea / Vomiting</p> <p>_____ Gas / Belching</p> <p>_____ Insulin Sensitivity</p> <p>_____ Hemorrhoids</p> <p>_____ Constipation</p> <p>_____ Diarrhea</p> <p>_____ Abdominal Pain</p> <p>_____ Indigestion / Heartburn</p> <p>_____ Over-Thinking</p> <p>_____ Tendency to Gain Weight</p> <p>_____ Brain Foggy</p>
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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.

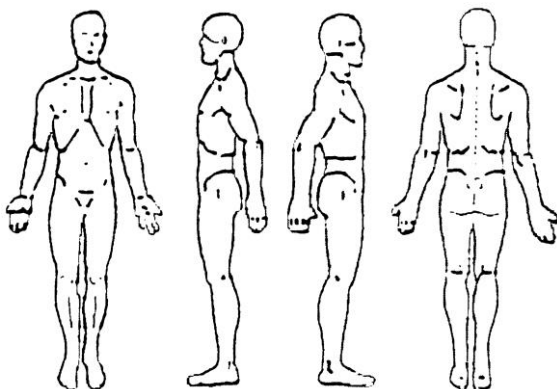
	You	Father	Mother	Spouse	Brother(s)	Sister(s)	Children
<i>Age</i>							
AIDS / HIV							
Alcohol							
Anxiety							
Arthritis							
Asthma / Hay Fever / Allergy							
Back Trouble							
Bursitis							
Cancer							
Constipation							
Depression							
Diabetes							
Digestive Trouble							
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

- | | | |
|--|--|---|
| <input type="checkbox"/> Muscle Cramps – Where? | <input type="checkbox"/> Muscle Pain / Rheumatism – Where? | <input type="checkbox"/> Arthritis – Where? |
| <input type="checkbox"/> Joint Swelling – Where? | <input type="checkbox"/> Tendonitis – Where? | <input type="checkbox"/> Bursitis – Where? |

Please mark problem areas on diagram:



Describe Pain and Location

- | | | |
|--------------------------------|---------------------------------------|---------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Burning | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Fixed | <input type="checkbox"/> 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 Inflamm. 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

Signature

Date _____

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.

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

Education, Experience, Degrees, Certificates, Credentials, Licenses, Certificates, and Registrations:

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.

Cash Fee Schedule:

Initial Acupuncture Treatment (incl. exam).....	\$150.00
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)

Insurance Fee Schedule:

Based on benefit coverage & allowed amount determined by the insurance company.

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



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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