# Holistic Integrative Wellness Centre, LLC

**NEW PATIENT INTAKE FORM**

Initial Appointment Date: _____

| PATIENT DATA | | |
|---|---|---|
| Last Name: | First Name: | Middle: |
| Address: | | |
| City: | State: | Zip Code: |
| Tel. (please check preferred #): ☐Home: | ☐Mobile: | ☐Work: |
| Email: | Fax: | |
| Would you like to receive email reminders prior to appointments? ☐Yes ☐No | | |
| Date of Birth: | Age: | Sex: |
| Race/Ethnicity: ☐American Indian ☐Asian ☐Black ☐Latino/Hispanic ☐Pacific Islander ☐White ☐ Other:_____ | | |
| Employment Status (check all that apply): ☐Full-time ☐Part-time ☐Retired ☐Unemployed ☐Self-Employed ☐Student | | |
| Occupation/Employer: | | |
| Emergency Contact: | Relationship: | Phone: |
| Referred by: | | |
| Marital Status: ☐Single ☐Married ☐Domestic Partner ☐Divorced ☐Widowed ☐Other:_____ | | |

| **PRIMARY CARE PHYSICIAN INFORMATION** | |
|---|---|
| Primary Physician: | Telephone: |
| Physician's Address (or name of clinic/hospital): | |

| **INSURANCE/SUPERBILL INFORMATION** | | |
|---|---|---|
| Insurance Company: | Policy Holder Name: | Relationship to Patient: |
| Policy #/ ID #: | Group #: | |
| Insurance Company Address: | | Telephone: |

**All information is kept confidential**

# Holistic Integrative Wellness Centre, LLC

**CHIEF COMPLAINT & TREATMENT HISTORY**

What health issue would you like to have treated? _____

_____

Have you received any treatment for this health issue? ☐Yes ☐No

Please describe:

_____

_____

**GENERAL HEALTH & TREATMENT HISTORY**

Have you had acupuncture before? ☐Yes ☐No
If yes, for what condition(s)?

Have you ever taken Herbal medication before? ☐Yes ☐No
If yes, for what condition(s)?

Have you had Aromatherapy before? ☐Yes ☐No
If yes, for what condition(s)?

Are you presently being treated for any (other) medical conditions? ☐Yes ☐No
Please describe: _____

_____

Please list/describe other health concerns, in order of importance (most to least).

_____

_____

Are you on a special or restricted diet? (e.g. vegetarian, vegan, low-carb, raw, Atkins, Zone, etc…)

Please list ALL known allergies:

_____

_____

_____

**All information is kept confidential**

## Holistic Integrative Wellness Centre, LLC

**MEDICATIONS / HERBS / SUPPLEMENTS** (list any you are currently taking):

MEDICATIONS:_____

_____

_____

_____

SUPPLEMENTS:_____

_____

_____

_____

HERBS:_____

_____

_____

_____

**EXERCISE**

Do you exercise regularly? ☐Yes ☐No

If yes, please describe your program of exercise: _____

_____

**HABITS** (Pleases check any that apply to you, past or present):

| | | | | | |
|---|---|---|---|---|---|
| Coffee: | ☐Yes | ☐No | Cups per week: | Age Started: | Age Quit: |
| Tobacco: | ☐Yes | ☐No | Cigarettes per day: | Age Started: | Age Quit: |
| Alcohol: | ☐Yes | ☐No | Drinks per week: | Age Started: | Age Quit: |
| Marijuana: | ☐Yes | ☐No | Use per week: | Age Started: | Age Quit: |
| Other: | | | Use per week: | Age Started: | Age Quit: |

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# Holistic Integrative Wellness Centre, LLC

**HEALTH HISTORY**
(Please place an X where applicable)

| Condition | Present | Past | Condition | Present | Past |
|---|---|---|---|---|---|
| ***General*** | | | ***Cardiovascular*** | | |
| Unexplained Weight Loss | | | Chest Pain | | |
| Unexplained Weight Gain | | | Palpitations | | |
| Chills | | | Pacemaker | | |
| Fever | | | | | |
| Insomnia | | | ***Respiratory*** | | |
| Fatigue | | | Cough | | |
| Night Sweats | | | Wheezing | | |
| Poor Appetite | | | Short of Breath | | |
| Excessive Appetite | | | Bronchitis | | |
| Excessive Thirst | | | Frequent Colds | | |
| Decrease Thirst | | | Coughing Blood | | |
| | | | Phlegm | | |
| ***Skin/Hair/Nails*** | | | | | |
| Swelling | | | ***Gastrointestinal*** | | |
| Rashes | | | Heartburn/Reflux | | |
| Itchy Skin | | | Diarrhea | | |
| Skin Lesions | | | Constipation | | |
| Acne | | | Blood in Stool | | |
| Dry Brittle Hair | | | Pain in Bowel | | |
| Abnormal Hair loss | | | Frequent Gas | | |
| Dry Brittle Nails | | | Hemorrhoids | | |
| | | | Nausea | | |
| ***Ears/Nose/Throat*** | | | Vomiting | | |
| Hearing Loss | | | Black Stools | | |
| Ear Ringing | | | IBS | | |
| Nose Bleeds | | | | | |
| Sinus Infections | | | ***Genitourinary*** | | |
| Trouble Swallowing | | | Leaking Urine | | |
| Hoarseness | | | Urgency | | |
| Recurrent Sore Throat | | | Frequent Urine | | |
| | | | Pain/Burning | | |
| ***Eyes*** | | | Blood in Urine | | |
| Change in Vision | | | Urinate During Night | | |
| Eye Pain/Itching | | | Frequent UTI | | |
| Eye Redness | | | Difficulty Urinating | | |
| Eye Discharge | | | Genital Pain | | |
| | | | Genital Itching | | |
| ***Extremities*** | | | Genital Lesions | | |
| Cold Hands | | | Discharge | | |
| Cold Feet | | | | | |
| Arm/Hand Swelling | | | ***Neurological*** | | |
| Leg/Feet Swelling | | | Headaches | | |

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## Holistic Integrative Wellness Centre, LLC

| | | | | | |
|---|---|---|---|---|---|
| Poor Circulation | | | Migraines | | |
| Sweaty Palms | | | Dizziness | | |
| | | | Fainting | | |
| ***Musculoskeletal*** | | | Memory Loss | | |
| Neck Pain | | | Dizziness | | |
| Back Pain | | | Numbness/Tingling | | |
| Muscle Pain | | | Unsteady Gait | | |
| Joint Pain | | | Frequent Falls | | |
| Muscle Weakness | | | Tremors | | |
| Bone Pain | | | Paralysis | | |
| | | | | | |
| ***Endocrine*** | | | ***Women Only*** | | |
| Heat Intolerance | | | Breast Lumps | | |
| Cold Intolerance | | | Nipple Discharge | | |
| | | | PMS(bloating, irritable) | | |
| ***Hematologic/Lymphatic*** | | | Menstrual Cramps | | |
| Swollen Glands | | | Irregular Cycle | | |
| Easy Bruising | | | Irregular Bleeding | | |
| | | | Clotting | | |
| ***Allergy/Immune*** | | | Hot Flashes | | |
| Allergies | | | Night Sweats | | |
| Frequent Infections | | | Freq Vaginal Infections | | |
| | | | Pelvic Infection | | |
| ***Psychological*** | | | Uterine Fibroids | | |
| Anxiety | | | Endometriosis | | |
| High Stress | | | Ovarian Cysts | | |
| Lack of Concentration | | | Cervix Problems | | |
| Depression | | | | | |
| Psycho-Emotional Issues | | | ***Men Only*** | | |
| | | | Impotence | | |
| | | | Enlarged Prostate | | |
| | | | Testicular issues | | |
| ***Major Surgeries:*** | | | | | |

| **FAMILY HEALTH HISTORY** (Please provide details where applicable): |
|---|
| Cancer or Tumors: |
| Diabetes (specify Type 1 or 2): |
| Heart Disease: |
| High Blood Pressure: |
| High Cholesterol: |
| Stroke: |

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# Holistic Integrative Wellness Centre, LLC

**INFORMED CONSENT TO TREATMENT AND TREATMENT POLICIES**

I,_____ , consent to receive acupuncture treatments and other procedures associated with holistic/alternative medicine by Cynthia D. Williams, L.Ac, RN, CA. I understand that the methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electric stimulation, tui-na massage gua sha, aromatherapy, herbal medicine, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment but that it may have side effects, including, but not limited to: bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Other risks of acupuncture treatment could include (although unusual and extremely rare) spontaneous miscarriage, nerve damage, and organ puncture, including lung puncture which could result in air in the chest cavity. Although the clinic uses sterile, disposable needles and maintains a clean and safe environment, infection is another possible risk of treatment.

Bruising and soreness is a common side effect of cupping and gua sha that may last for a few days. Risks associated with moxibustion treatment may include burns and/or scarring, although unusual and rare. I understand that while this document describes major risks of treatment, other unanticipated side effects may occur. I do not expect the Practitioner to be able to anticipate all possible complications from treatment, but I do wish to rely on the practitioner to exercise judgment during the course of treatment, which based upon the facts known and my condition, is in my best interests.

The herbs (which are from plant, animal, and mineral sources) that have been recommended are safe in the practice of Chinese Medicine, although some may be toxic if not taken as prescribed. Other possible side effects of herbal treatments are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I understand that aromatherapy is the use of essential oils from plants and that some may cause side effects or adverse reactions if not used properly. Possible side effects/adverse reactions include rash, asthma, headache, liver and nerve damage, and harm to a fetus. I understand that some herbs and essential oils may be inappropriate during pregnancy.

- **I will notify my practitioner if I am or become pregnant.**
- **I will notify my practitioner if I have or get a pacemaker or prosthetic heart valve.**
- **I agree to follow all treatments only as recommended/prescribed. If I am experiencing any side effects or difficulties I will notify practitioner as soon as possible.**
- **I understand the practitioner may review my lab reports, but all my records will be kept strictly confidential and will not be released without my consent.**

By voluntarily signing below, I am demonstrating that I have read (or have had read to me) this consent to treatment and treatment policies, have been told about the risks of acupuncture and other procedures, and no guarantees have been made. My questions have been answered and I wish to proceed.

Patient's/ Representative's Signature: Date:

_____ _____

**All information is kept confidential**

# Holistic Integrative Wellness Centre, LLC

**PAYMENT AND PERSONAL INSURANCE FINANCIAL AGREEMENT**

Holistic Integrative Wellness Centre would like to take a moment to welcome you to our office and familiarize you with our financial policies. You are financially responsible for all services rendered to you in this office. Payment is made in full (100%) for each visit at the time of visit unless special arrangements have been made with your provider. Payments may be made with Cash or Credit Card.

**Cancellation Policy**
No charge will be made for cancellations or appointment changes if 24 hours notice is given. For cancellations with less than 24 hours, a $25 fee will be charged. Payments need to be made in full by you.

**Insurance**
Currently, we do not do direct billing to insurance, however, many insurance policies reimburse for acupuncture treatments. Upon request, we will happily provide you with a superbill after your treatment so you can submit your claim. A superbill is an invoice using standardized codes for treatments received. Please call your insurance carrier to find out about your insurance plan's coverage for acupuncture and related services.

**I have read and agree to the above. I authorize the provider to release all information necessary to secure the payment of benefits.**

Responsible Party Signature: Date:

_____ _____

Practitioner's Signature: Date:

_____ _____

**All information is kept confidential**

# Holistic Integrative Wellness Centre, LLC

**HIPAA DATA USE AGREEMENT**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**
This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

**1. Uses and Disclosures of Protected Health Information**
Your protected health information may be used and disclosed by your practitioner, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your practitioner's practice.
Following are examples of the types of uses and disclosures of your protected health information that your practitioner's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians or practitioners who may be treating you. For example, your protected health information may be provided to a physician/practitioner to whom you have been referred to ensure that they have the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician/practitioner, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your practitioner.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your practitioner's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object.
We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

**Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object:**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your practitioner may, using professional judgment, determine whether the disclosure is in your best interest.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**2. Your Rights**
Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your practioner and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.
Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your practitioner is not required to agree to a restriction that you may request. If your practitioner does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your practitioner.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your practitioner amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**3. Complaints**
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

**You have the right to obtain a paper copy of this notice from us, upon request.**

**You may contact your practitioner if you have any other questions about privacy practices.**

# Holistic Integrative Wellness Centre, LLC

**Practice Privacy Policy/HIPPA Acknowledgement**

**I have read and/or received a copy of the Practice Privacy Policy and agree to its terms.**

Patient's/ Representative's Signature: Date:

_____ _____

**All information is kept confidential**