



## Integrative Path Therapies, LLC Acupuncture & Dry Needling

Dear New Patient,

Thank you for choosing Integrative Path Therapies for your acupuncture needs. We do our best to ensure that you will receive the highest quality of care.

My name is Gisela Herrera Pardo. I am an acupuncture physician. I have special interest in treating people who have musculoskeletal pain and disorders. These include neck and low back pain as well as more complicated conditions such as fibromyalgia, stenosis, and herniated disks causing chronic pain. I also enjoy treating people with emotional disorders, such as anxiety, depression, mild obsessive-compulsive disorder, and those individuals grieving. I believe emotions are a key component in most diseases. I like to guide people with nutrition, especially since there is so much information that contradicts itself.

Enclosed are 3 forms for you to print and fill out. Please bring these to your initial appointment. These forms include:

1. Initial visit intake form (pages 2-5)
2. Notice of privacy Policies (pages 6-7)
3. Arbitration/consent (pages 8-9)

Please eat at least two hours before your treatment. When you arrive, please let me know if you are nervous about the treatment, as it is common to be anxious.

Our address is 5190 26<sup>th</sup> Street West, Bradenton, FL 34207, Suite G. We look forward to meeting you!



Warmly,

Gisela Herrera Pardo, DOM  
Acupuncture Physician

# Integrative Path Therapies, LLC

## Acupuncture & Dry Needling



### Intake Form

#### Personal Information

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (Day): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Telephone (Night): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Telephone (Mobile): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

Who is your primary health care provider/MD? \_\_\_\_\_

Occupation: \_\_\_\_\_

\_\_\_\_\_

Referral Source: \_\_\_\_\_

Ins Carrier: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Member ID#: \_\_\_\_\_

Phone: \_\_\_\_\_

Insured's name: \_\_\_\_\_

Group #: \_\_\_\_\_

#### Main Complaint

Please identify your **3** major health concerns

1. _____ _____ How Long have you had this problem? _____	2. _____ _____ How Long have you had this problem? _____	3. _____ _____ How Long have you had this problem? _____
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Have you been given a diagnosis for these problems? \_\_\_\_\_

What other treatments have you tried and what were the outcomes? \_\_\_\_\_

\_\_\_\_\_

**Personal Medical History** (Please include your childhood history)

<b>Illnesses</b>	
<b>Surgeries</b>	
<b>Significant Trauma</b> (i.e. motor vehicle accidents, fractures, etc.)	
<b>Do have a history of current or past infectious disease?</b> Please describe	
<b>Medicines</b> (please list all medications, herbs, vitamins and over the counter drugs)	
<b>Allergies/Sensitivities</b> (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

**General** (please check all that apply)

- |  |  |                                   |                                      |  |
|--|--|-----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Changes in Appetite | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tremors     | <input type="checkbox"/> Easy to Bleed or Bruise |
| <input type="checkbox"/> Hearing Loss  | <input type="checkbox"/> Night Sweats        | <input type="checkbox"/> Fevers   | <input type="checkbox"/> Cravings    | <input type="checkbox"/> Puffiness or Swelling   |
| <input type="checkbox"/> Strong Thirst | <input type="checkbox"/> Poor Sleep          | <input type="checkbox"/> Chills   | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Sudden Energy Drops     |
| <input type="checkbox"/> Poor Balance  | <input type="checkbox"/> Sweat Easily        | <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Wight Gain  | <input type="checkbox"/> Other:                  |

**Skin and Hair**

- |                                      |                                  |                                  |                                    |                                       |
|--------------------------------------|----------------------------------|----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Hives   | <input type="checkbox"/> Eczema  | <input type="checkbox"/> Dandruff  | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Skin Ulcers | <input type="checkbox"/> Itching | <input type="checkbox"/> Pimples | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Other:       |

**Head, Eyes, Ears, Nose and Throat**

- |  |                                      |  |   |   |
|--|--------------------------------------|--|---|---|
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Dizziness   | <input type="checkbox"/> TMJ Pain            | <input type="checkbox"/> Smell Problems | <input type="checkbox"/> Spots in front of eyes |
| <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Headaches   | <input type="checkbox"/> Toothache           | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Recurrent Sore Throat  |
| <input type="checkbox"/> Eye Strain/Pain | <input type="checkbox"/> Concussions | <input type="checkbox"/> Taste Problems      | <input type="checkbox"/> Ear Aches      | <input type="checkbox"/> Other:                 |
| <input type="checkbox"/> Blurry Vision   | <input type="checkbox"/> Migraines   | <input type="checkbox"/> Lip or Tongue Sores | <input type="checkbox"/> Ear Ringing    |   |
| <input type="checkbox"/> Floaters        | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Nose Bleeds         | <input type="checkbox"/> Poor Hearing   |   |

**Cardiovascular**

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Swelling of Hands | <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Swelling of Feet   | <input type="checkbox"/> Fainting          | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Palpitations       |
| <input type="checkbox"/> Chest Pain          | <input type="checkbox"/> Lightheadedness    | <input type="checkbox"/> Other:            |  |   |

**Respiratory**

- |                                    |  |  |   |  |
|------------------------------------|--|--|---|--|
| <input type="checkbox"/> Cough     | <input type="checkbox"/> Phlegm            | <input type="checkbox"/> Asthma        | <input type="checkbox"/> Bronchitis           | <input type="checkbox"/> Coughing up Blood |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Painful breathing | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Other:            |

**Gastro-Intestinal**

- |                                       |   |   |                                      |  |
|---------------------------------------|---|---|--------------------------------------|--|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Bad Breath     | <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Blood in Stools |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Ulcers         | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids     |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Intestinal Gas       | <input type="checkbox"/> Belching    | <input type="checkbox"/> Other:          |

**Urology**

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Painful Urination        | <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Cloudy Urine                  | <input type="checkbox"/> Pain in Groin Area   | <input type="checkbox"/> Urgency to Urinate |
| <input type="checkbox"/> Frequent Urination       | <input type="checkbox"/> Kidney Stones          | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Blood in Urine     |
| <input type="checkbox"/> Frequent Night Urination | <input type="checkbox"/> Other:                 |  |   |   |

**Neuro-Psychological**

- |  |   |  |                                      |                                     |
|--|---|--|--------------------------------------|-------------------------------------|
| <input type="checkbox"/> Seizures          | <input type="checkbox"/> Twitches             | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Tremors    |
| <input type="checkbox"/> Areas of Numbness | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Stress               | <input type="checkbox"/> Mood Swings     | <input type="checkbox"/> Other:      |                                     |

**Gynecology**

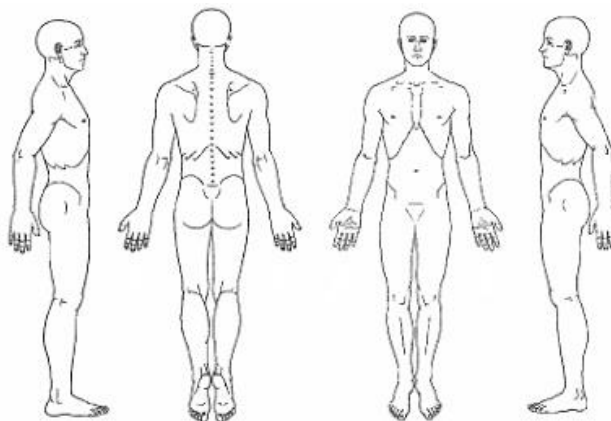
- |  |  |                                |   |                                       |
|--|--|--------------------------------|---|---------------------------------------|
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Spotting          | <input type="checkbox"/> PMS   | <input type="checkbox"/> Fertility Problems | <input type="checkbox"/> Menopausal   |
| <input type="checkbox"/> Painful Periods   | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Clots | <input type="checkbox"/> Yeast Infections   | <input type="checkbox"/> Breast Lumps |

\_\_\_ Age of menses  
 \_\_\_ Duration of menses  
 \_\_\_ Date of last menses  
 \_\_\_ # of pregnancies  
 \_\_\_ # of births

**Musculo-Skeletal**

- |                                      |   |  |  |                                    |
|--------------------------------------|---|--|--|------------------------------------|
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Muscle Spasms      | <input type="checkbox"/> Pain with Weather Changes | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Weak Joints | <input type="checkbox"/> Pain with Activity | <input type="checkbox"/> Pain after Waking         | <input type="checkbox"/> Other:          |                                    |

Please mark any areas of pain or discomfort:



**AUTHORIZATION AND RELEASE**

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the provider for any insurance benefits. If payments are issued to patient, patient will endorse check to provider and forward to provider upon receipt.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered. I understand and accept that I am financially responsible for any, and all charges incurred for professional services rendered to me. I also understand and accept that I am responsible for any charges incurred should collection proceedings become necessary to enforce this agreement.

**FINANCIAL POLICY AND ARRANGEMENTS**

We will be happy to bill your insurance and will accept their payment; however, any coinsurance and copay will be collected at the time service is rendered. Any difference will be included in our monthly statements and payments are expected upon receipt. Payment for service is due at the time services are rendered. Any patient responsibility transferred by your insurance is due immediately after is determined by your insurance and communicated by us through our monthly statements.

**Cancelations:** There will be a fee of \$25.00 to the patient’s account for any last-minute cancelations. Any cancellations must be made at least 24 hours prior to your appointment.

**No-Show:** There will be a fee of \$50.00 to the patient’s account for missed appointments. If a patient does not arrive 20 minutes after their appointment, it will automatically be considered a no show.

**All returned checks are subject to an additional \$35 fee.**

I have read and understood the above.

Patients Name \_\_\_\_\_ Date \_\_\_\_\_

X \_\_\_\_\_



# Integrative Path Therapies, LLC

## Acupuncture & Dry Needling

### Notice of Privacy Practices

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected. Your health information may be used and disclosed by your acupuncture physician, our office staff and others outside of our office that 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 the acupuncture physician's practice.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- From health care providers, insurance companies, workman's comp and your employer, and other third part administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - e.g. your name, address, Social Security number, etc.).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (941) 896-9328.

Patient acknowledgement of privacy practices:

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Patient name

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Date

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Signature: patient or representative

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Relationship to patient (if other than patient)