Wellstream Healing & Acupuncture

Sarina T. Hrubesch, DACM, LAc
561.420.0763
wellstreamhealth@gmail.com

## CONFIDENTIAL NEW PATIENT INFORMATION

Name ____________________ Date ____________

Phone # ____________ Email ____________________

Address ____________________________________

City ____________________ State ________ Zip ________

Date of Birth ____________ Marital Status ____________

Age ________ Height ________ Weight ________

Occupation ____________________ Employer ____________________

Emergency Contact ____________________ Cell # ____________

Relationship to Patient ____________________ Home # ____________

Primary Physician ____________________ Phone # ____________

Doctor's Diagnosis ____________________________________

How did you hear about our clinic/Whom may we thank for the referral? ____________________

**PRIVACY RIGHTS / HIPAA NOTICE**
**Our office is dedicated to providing health services with respect for privacy.**

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies, and anyone with whom they do business. HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. Please take a few minutes to review these rights. We are happy to answer any questions you may have.

**I hereby acknowledge that I understand and have received a copy of Wellstream Healing & Acupuncture's Notice of Privacy Practices.**
I consent to the Practice's use and disclosure of my protected health information pursuant to HIPAA regulations.

Patient Name (Please print) ____________________________________

Patient Signature ____________________ Date ____________

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# Medical History

*The purpose of this form is to understand your past and present medical history*

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| Primary Complaint | What makes it better? What makes it worse? |
| --- | --- |
| Secondary Complaint | What makes it better? What makes it worse? |
| Other Compaints | What makes it better? What makes it worse? |

## Tell Us About Your Past Medical History

Please Mark The Check Box If You Previously Suffered From These Conditions.

- ☐ Asthma
- ☐ Arteriosclerosis
- ☐ Colitis
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ HIV
- ☐ Herpes Simplez
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Mono
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Bronchitis
- ☐ Chronic Fatigue
- ☐ Diabetes Type 1
- ☐ Emphysema
- ☐ Gallstones
- ☐ Hepatitis B
- ☐ Hypertension
- ☐ Hyper Thyroid
- ☐ Hypo Thyroid
- ☐ Meningitis
- ☐ Mumps
- ☐ PTSD
- ☐ Rheumatic Fever
- ☐ STD's
- ☐ Sudden Weight Loss
- ☐ Ulcers
- ☐ Appendicitis
- ☐ Bird Flu
- ☐ Depression
- ☐ Diabetes Type 2
- ☐ Eating Disorder
- ☐ Goiter
- ☐ Hepatitis C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mental Illness
- ☐ Pneumonia
- ☐ Physical Abuse
- ☐ Reynaud's Disease
- ☐ Stroke
- ☐ Sudden Weight Gain
- ☐ Uterine Fibroids

| Addictions |
| --- |
| Cancer? What Type? |
| Hospitalizations, Operations and Significant Traumas |

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**Your Family's Medical History**

| Addictions | Asthma |
|---|---|
| Cancer | Diabetes |
| Fatty Liver | High Blood Pressure |
| Heart Disease | Mental Disease |
| Stroke | Thyroid Disease |

**Tell Us About Your Lifestyle**

| Diet |
|---|
| Exercise |
| Stress Level |

Mark any of the following that apply to you.

☐ Drink Coffee
☐ Drink Soda
☐ Drink Alcohol
☐ Smoke Tobacco
☐ Smoke Marijuana
☐ Take Recreational Drugs

**Sleep**
Do you experience any of the following?

☐ Insomnia
☐ Wake Easily
☐ Nightmares
☐ Difficulty Falling Asleep
☐ Difficulty Staying Asleep
☐ Wake Frequently
☐ Wake Early
☐ Restless
☐ Sleep Soundly
☐ Night Sweats
☐ Snoring
☐ Sleep Apnea

**Current State of Health**

My Body Temperature Feels?

☐ Hot
☐ Cold
☐ Normal

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**General Symptoms**

- ☐ Edema
- ☐ Fever
- ☐ Aversion To Cold
- ☐ Low Thirst
- ☐ Insomnia
- ☐ Foggy Headed
- ☐ Bruise Easy
- ☐ Body Aches
- ☐ Aversion To Heat
- ☐ Poor Appetite
- ☐ Fatigue
- ☐ Dizziness
- ☐ Chills
- ☐ Aversion To Wind
- ☐ Strong Thirst
- ☐ Night Sweats
- ☐ Nasal Congestion
- ☐ Short Of Breat

**Head, Eyes, Ears, Nose & Throat Symptoms**

- ☐ Dry Eyes
- ☐ Poor Night Vision
- ☐ Difficult to Focus
- ☐ Ear Ringing: High Pitch
- ☐ Blocked Sinus
- ☐ Hoarse Voice
- ☐ Mouth Sores/Ulcers
- ☐ TMJ
- ☐ Sore Throat
- ☐ Red Eyes
- ☐ Floaters
- ☐ Cataracts
- ☐ Ear Ringing: Low Pitch
- ☐ Grinding Teeth
- ☐ Headaches
- ☐ Migraines
- ☐ Facial Pain
- ☐ Unexplained lump in Throat
- ☐ Blurry Vision
- ☐ Eye Strain
- ☐ Glasses/Contacts
- ☐ Poor Hearing
- ☐ Dental Problems
- ☐ Concussion
- ☐ Nose Bleeds
- ☐ Ear Aches
- ☐ Excess Saliv

**Cardiovascular Symptoms, Signs & Diseases**

- ☐ High Blood Pressure
- ☐ Heart Beating Fast
- ☐ Swelling of Hand/Feet
- ☐ Fainting
- ☐ Low Blood Pressure
- ☐ Heart Palpitations
- ☐ Phlebitis
- ☐ Left Arm Pain
- ☐ Irregular Heart Beat
- ☐ Cold Hand/Feet
- ☐ Chest Pain
- ☐ Varicose Veins

**Respiratory Signs & Symptoms**

- ☐ Dry Cough
- ☐ Phlegmy
- ☐ Pain When Breathing Deep
- ☐ Post Nasal Drip
- ☐ Wet Cough
- ☐ Pneumonia
- ☐ Short of Breath
- ☐ Labored Breathing
- ☐ Bronchitis
- ☐ Asthma
- ☐ Chest Tightness
- ☐ Breath Feels Hot

**GastroIntestinal**

- ☐ Nausea
- ☐ Gas
- ☐ Hiccup
- ☐ Indigestion
- ☐ Anal Fissures
- ☐ Constipation
- ☐ Bloating
- ☐ Acid Regurgitation
- ☐ Bad Breath
- ☐ Itchy Anus
- ☐ Diarrhea
- ☐ Abdominal Pain/Cramp
- ☐ Belching
- ☐ Rectal Pain
- ☐ Hemorrhoids

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**Genitourinary**

- ☐ Frequent Urination
- ☐ Incomplete Urination
- ☐ Unable to Hold Urine
- ☐ Smelly Urine
- ☐ Wet Dreams
- ☐ Low Semen Volume (Men)
- ☐ Genital Sores
- ☐ Wakes Up To Urinate
- ☐ Decrease Flow
- ☐ Bedwetting
- ☐ Dark Yellow Urine
- ☐ Impotence (Men)
- ☐ Premature Ejaculation
- ☐ High Libido
- ☐ Pain During Urination
- ☐ Decrease Stream Power
- ☐ Urinary Tract Infection
- ☐ Kidney Stones
- ☐ Enlarged Prostate (Men)
- ☐ Gental Itching
- ☐ Low Libido

**Gynecological & Obstetrics (Women Only)**

- ☐ Currently Pregnant
- ☐ No Menstrual Cycle
- ☐ PCOS
- ☐ Uterine Fibroids
- ☐ Irregular Menses
- ☐ Endometriosis
- ☐ PMS
- ☐ Vaginal Sores
- ☐ Menstrual Clots
- ☐ Ovarian Cysts
- ☐ PID
- ☐ Frequent Yeast Infections

**Gynecological**

| Last Menstrual Period | Date of Last PAP |
|---|---|
| Age Menses Started | Number of Days Between Periods? |
| How Many Days Do You Bleed (During Period)? | Menstrual Blood Clots |
| Color of Menstrual Blood | What is Your Flow Like? |
| Irregular Menses | Mid-Cycle Bleeding? |
| Menopause | Birth Control |
| Breast Lumps | Breast Lumps |

**Obstetrics**

| If currently pregnant, how many months? | Previous Live Births? |
|---|---|
| Premature Births? | Any Miscarriages? |
| Previous Abortions? | IVF |

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**Musculoskeletal**

What Areas Are Painful?

- ☐ Head
- ☐ Upper Back
- ☐ Ribs
- ☐ Upper Leg
- ☐ Knee
- ☐ Fingers
- ☐ General Muscle Weakness
- ☐ Neck
- ☐ Middle Back
- ☐ Wrist
- ☐ Side of Leg
- ☐ Ankle
- ☐ Toes
- ☐ Muscle Tightness
- ☐ Shoulder
- ☐ Lower Back
- ☐ Hip
- ☐ Lower Leg
- ☐ Foot
- ☐ Groin
- ☐ Full Body Aches/Pai

**Neuropsychological**

Do You Feel Numbness?

- ☐ Face
- ☐ Wrists
- ☐ Legs
- ☐ Shoulder
- ☐ Fingers
- ☐ Ankles
- ☐ Arms
- ☐ Toes
- ☐ Foot

Frequent Emotions

- ☐ Fear
- ☐ Depression
- ☐ Suicidal
- ☐ Grief
- ☐ Anxiety
- ☐ Irritable
- ☐ Worried
- ☐ Anger
- ☐ Manic

General Symptoms

- ☐ Dizziness
- ☐ Memory Loss
- ☐ Loss of Balance
- ☐ Tremors
- ☐ Lack of Coordination
- ☐ Panic A

| Paralysis | Other Neurological Issues |
|---|---|
| | |

**Is There Anything We Missed or You Want To Tell Us?**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

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# INFORMED CONSENT

I, ______________________________, hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now, or in the future, treat me while employed by, working with or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, TuiNa, Chinese herbal medicine, and nutritional or lifestyle counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture, including pneumothorax (lung puncture). Infection is another possible risk, although the clinician uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of East Asian Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that any services, consultation, advice, products, or treatments that I receive from the acupuncturist are not a substitute or replacement for conventional western medical services or treatments.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Wellstream Healing & Acupuncture, PLLC
Doctor of Acupuncture: Sarina T. Hrubesch, DACM, LAc License # VA: 0121-001058; FL: AP3860

Patient signature: ______________________________ Date: ______________

OR

Patient Representative: ______________________________ Date: ______________

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(indicate relationship to patient)

**PATIENT CONSENT FORM – PRIVACY**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Wellstream Healing & Acupuncture, PLLC ("Wellstream") provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- Wellstream has a Notice of Privacy Practices and that the Patient has the opportunity to review this Notice
- Wellstream reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information, but Wellstream does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Wellstream may condition treatment upon the execution of this Consent.

Printed Name: ________________________________________________________

Signature: ________________________________________ Date: ______________

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# NOTICE OF PRIVACY PRACTICES

**This summary of our privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

We understand that your medical information is personal to you, and we are committed to protecting all information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples:

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and/or tissue donation
- For workers compensation programs
- In response to certain requests arising out of lawsuits

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

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## RECOMMENDATION FOR EXAMINATION BY A PHYSICIAN

Wellstream recommends that you be examined by a physician regarding the condition for which you are seeking acupuncture treatment.

**I understand this recommendation.**

Signature: _______________________________________________ Date: _________________

Virginia law requires the presentation of this form in the absence of written evidence of a diagnostic exam within the last six months from a licensed practitioner of medicine, osteopathy, chiropractic, or podiatry regarding the condition for which you are seeking treatment. (Code of Virginia §54.1-2956.9, 18 VAC 85-110-10).

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# PATIENT CARE FINANCIAL AGREEMENT POLICY

Effective September 1, 2017

Thank you for choosing Wellstream Healing & Acupuncture as your healthcare provider. We are committed to your treatment being successful, and our office policy has been established to ensure that the best health service can be provided to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

**Full payment is due at the time of your service. We accept Zelle, check, and credit cards.**

## Missed Appointments and Cancellations

**In order to prevent being charged a cancellation fee, please give at least 24 hours notice of cancellation.**

When we make an appointment, we are reserving time just for you. Sufficient cancellation notice allows us to offer your time to another patient who may be waiting for an appointment. Missed appointments without 24-hour notice will be charged the full amount. For patients arriving more than 15 minutes late, you may be asked to reschedule your appointment if there is not sufficient time to provide the best treatment to you, or to have a shortened session. We will do our best to provide sufficient treatment, schedule permitting. Please help us provide the best care to you by keeping scheduled appointments in a timely manner. Late cancellations due to emergencies are understandable, in those cases the cancellation fee will be waived.

## Regarding Insurance

Check with your insurer to find out if acupuncture is included in your benefits. The full cost of services is ultimately your responsibility, and payment is due in full at the time of each visit. Should it be requested, we will provide you with a superbill so that you may submit and process with your insurance provider. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance programs. Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. Insurance companies do not reimburse for cancelled sessions. Please note that supplements and/or herbal formulas supplied as part of your treatment are not typically covered by insurance.

**There is a $35 fee for all returned checks. Payment is due in full at time of service.**

**My signature below certifies that I have read and understand the above Financial Policy and agree to be responsible for full payment of all services rendered to myself and/or any member of my family.**

**In order to avoid a late cancellation fee, I agree to give at least 24 hours notice.**

Printed Name: ______________________________________________ Date: ____________________

Signature: ____________________________________________________________________________