New Patient Intake Form

Harmony Acupuncture and Wellness LLC

PATIENT INFORMATION (Please print)			
Patient Name		Date of Birth	Age
Address	City	State	Zip
Phone	Work	Cell	
Best Time/Which # to Call	Email		
Social Security Number	Sex: Male ___ Female ___	Marital Status: Single___ Married___ Divorced ___ Widowed___	
Occupation	Employer & Telephone Number		
Emergency Contact & Relationship	Phone		
Website referral or who referred you?			

INSURANCE INFORMATION	
PRIMARY INSURANCE	
Name of Insurance Company	HSA Acct: Y / N
Address	
Policy #	Group #
Subscriber Name	D.O.B
Subscriber SS #	
SECONDARY INSURANCE	
Name of Insurance Company	
Address	
Policy #	Policy #
Subscriber Name	Subscriber Name
Subscriber SS #	

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Harmony Acupuncture and Wellness LLC for any services furnished me by the physician. I authorize any holder of medical information about me to be released to the Center of Medicare and Medicaid services and its agents any information to determine these benefits payable for related services.

_____

Patient Signature **Date**

I, undersigned, authorize payment of medical benefits to Harmony Acupuncture and Wellness LLC for any service furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize you to release to my insurance company or their agent, information concerning health care, treatment, or supply provided to me. This information will be used for purpose of evaluating and administering claims benefits.

_____

Patient Signature **Date**

Patient Information – Page 2

1) List of chief complaints in order of severity:

1. _____ For how long: _____
2. _____ For how long:_____
3. _____ For how long: _____

2) What is the severity of your problem?

(best) 1 2 3 4 5 6 7 8 9 10 (worst)

3) Do you have a history of chronic pain? Yes ☐ NO ☐

4) Are you experiencing pain right now? Yes ☐ No ☐

5) If Yes, where is the pain?

_____

6) Does the pain travel? Yes ☐ No ☐

If yes, where?

_____

7) If yes, what number best describes your pain?

0-10 Pain Intensity Numeric Rating Scale (NRS)

(best) 1 2 3 4 5 6 7 8 9 10 (worst)

8) Circle any activities that aggravate the condition:

Walking Lifting Coughing Sitting Bending Sneezing Sleeping

Other: _____

9) Circle any activities that alleviate the condition:

Rest Standing Heat Exercise Lying Down Ice Sitting Massage

Other: _____

10) How are your symptoms affecting your lifestyle? (i.e. job, relationships, recreational activities, household chores)

_____

11) Do you currently have, or have you had any of the following condition or symptoms?

__Headaches	**__Neck Pain**	**__Ringing in ears**	**__Fibromyalgia**
__High Blood Pressure	**__Numbness or**	**__Loss of balance**	**__stomach problem**
__Shortness of Breath	**tingling**	**__Nervousness**	**__ Other**
__Loss ofsmell/taste	**(arms and hands)**	**__Cancer**	**_____**
__ Heart condition	**(Legs)**	**__HIV**	**_____**
__ Diabetes	**__Hip pain**	**__Dizziness**	**_____**
__chest pain	**__Wrist of hand pain**	**__Depression**	
__Fatigue	**__shoulder Pain**	**__Anxiety**	
__vertigo	**__Lower back pain**	**__Hepatitis**	

12) List your hospitalizations, operation, and/or serious illness history:

_____

_____

_____

13) Allergies:

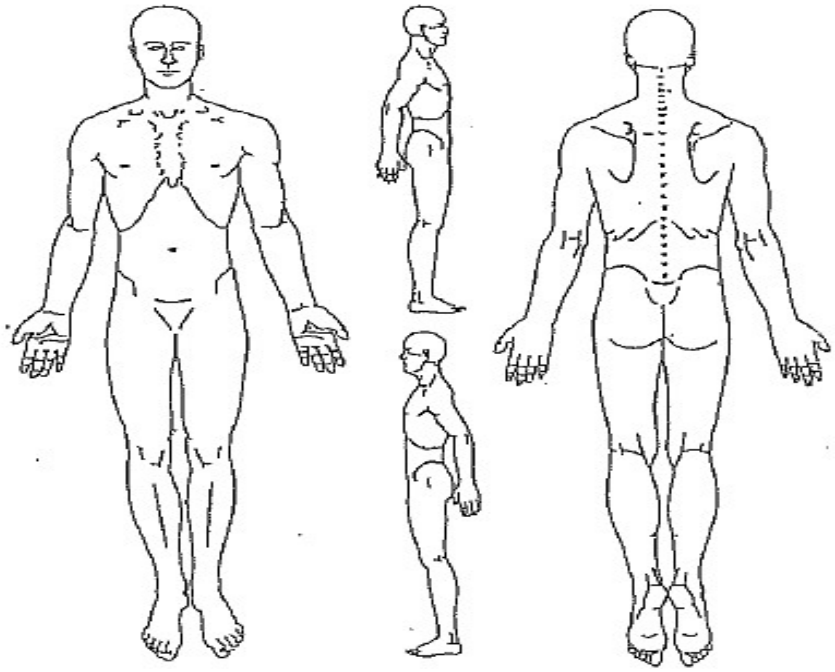
_____

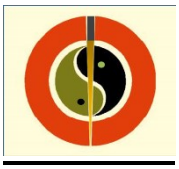
14) List all the medications you are currently taking:

_____

_____

15) <u>Indicate on the diagram where your pain is:</u>





HIPPA COMPLIANCE ACKNOWLEDGEMENT

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
THIS NOTICE IS IN EFFECT AS OF April 15, 2003

PATIENT'S STATEMENT OF AUTHORIZATION AND ACKNOWLEDGEMENT

a) Is required by Federal Law to maintain the privacy of your protected health information (PHI), and to provide you with a copy of this Privacy Notice detailing Harmony Acupuncture and Wellness LLC legal duties and privacy practices with respect to your PHI.
b) May be required by State Law to maintain greater restrictions on the use or release of your PHI than that which is provided under federal law, Harmony Acupuncture and Wellness LLC is required to, and will comply with all required State statutes.
c) Is required to abide by the terms of this Privacy Notice.
d) Reserves the right to change the terms of this Privacy Notice to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
e) Will distribute any revised Privacy Notice to you prior implementation.
f) Will comply with our complaint policy, and will not retaliate against you for filling a complaint.

By subscribing my name below, I acknowledge that I have read and understood this Privacy Notice. Furthermore, I give Harmony Acupuncture and Wellness LLC THE EXPRESSED WRITTEN CONSENT TO DISPLAY MY NAME IN ANY "In-Office" usages including, but not limited to sign-in sheet, files, and charts. I, also understand that if my name is requested to be used for promotional purposes outside of the office, a separate acknowledge of permission will be made in writing

ACCEPT TERMS:

_____ _____

PATIENT SIGNATURE **DATE**