Health in Motion Wellness Center

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New Patient Packet

It is very important the information given is complete and accurate to assist you properly in your healing process.
Note: Information provided on this form is confidential.

Please Print Clearly Today's Date ____/____/_____

BACKGROUND INFORMATION

Name _____Date of Birth ____/____/_____ Age____ Sex □ Male □ Female

Address_____City/ State/ Zip _____

Phone # Home_____Work_____ Mobile _____

Email_____What is the best way to reach you? Home / Work / Mobile / Email

Occupation_____ Emergency Contact /Nearest Relative_____Phone #_____

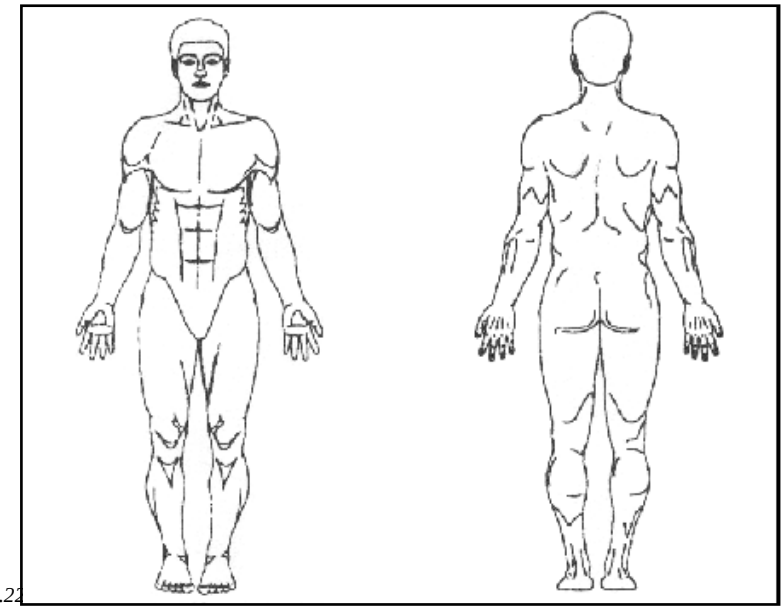
Physician_____ Physician's Phone #_____Social Security #_____-_____-_____

How did you hear about us? □ Friend □ Relative □ Website □ UHC Network □ Dr.:_____□ Other_____

What health condition(s)/issue(s) would you like treated? Please list in order of priority.

Condition/Issue	Onset Sudden	Medical Diagnosis	What Treatment Have you Received?	Symptoms Better by	Symptoms Worse by
	Y / N		□ Chiro □ ACU □ PT □ Injections □ Counseling		
	Y / N		□ Chiro □ ACU □ PT □ Injections □ Counseling		
	Y / N		□ Chiro □ ACU □ PT □ Injections □ Counseling		
	Y / N		□ Chiro □ ACU □ PT □ Injections □ Counseling		

On the following drawings, shade in the areas where you feel should be addressed.



PAST MEDICAL HISTORY

Have you had any of these condition(s)? Check all that apply:

- ❑ AIDS/HIV
- ❑ Alcoholism
- ❑ Allergies (food, latex)
- ❑ Asthma
- ❑ Birth Trauma
- ❑ Cancer
- ❑ Diabetes
- ❑ Drug Addictions
- ❑ Emphysema
- ❑ Fibromyalgia
- ❑ Heart Disease
- ❑ Hepatitis A/B/C
- ❑ Herpes
- ❑ Joint Replacement(s)
- ❑ Lyme Disease
- ❑ Lymph Node(s) Removed
- ❑ Multiple Sclerosis
- ❑ Pacemaker
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seasonal Allergies
- ❑ Seizures
- ❑ Sinus Infections
- ❑ Tuberculosis
- ❑ Operations_____
- ❑ Other_____

Family Medical History: (Please list any significant family illnesses, e.g. diabetes, heart disease, respiratory conditions, blood pressure, neurological disorders, psychological disorders, arthritis)

Mother:_____

Father:_____

Siblings:_____

Grandparents:_____

CURRENT MEDICAL HISTORY

Is this your first experience in Oriental Medicine? Yes / No How do you feel about Acupuncture?_____

Exercise & Energy: How is your energy?_____

What time of day is your energy: Highest?_____ Lowest?_____

Do you fatigue easily? Y / N What kind of exercise do you do?_____How often do you exercise?_____

Emotions & Sleep: How do you feel emotionally?_____

Do you have (check all that apply): ☐Panic Attacks ☐Depression ☐Anxiety ☐Bad Temper ☐Nervousness ☐Fear Attacks ☐Poor Memory ☐ Difficult Concentration

Are you in a relationship? Yes / No How do you feel about your relationship?_____

How do you hold stress?_____ How do you relax?_____

How do you feel about your work?_____ How long do you normally sleep? _____hrs./night

I have difficulties with (check all that apply): ☐Falling Asleep ☐Staying Asleep ☐Dream-disturbed Sleep

☐Waking up at about _____AM/PM and not being able to fall asleep again ☐Other_____

Gastrointestinal: I have (check all that apply): ☐Belching ☐Nausea ☐Vomiting ☐Vomiting of Blood ☐Ulcers ☐Bloating ☐Acid Regurgitation ☐Heartburn ☐Hernia ☐Indigestion ☐Severe Stomach Pain

Bowel Movements: How often? _____time(s)/day _____days/wk.

I have (check all that apply): ☐Irregularity ☐Constipation ☐Diarrhea ☐Gas ☐Burning Sensation ☐Hemorrhoids ☐Undigested Food in Stool ☐Loose Stool ☐Hard Stool ☐Blood in Stool ☐Itchiness ☐Painful Bowel Movements ☐Other_____

Urinary: Urination: How often?_____time(s)/day Color: ☐Pale Yellow ☐Dark Yellow/Orange
I have or had (check all that apply): ☐Trouble Starting Stream ☐Frequent Urination ☐Incontinence ☐Pain ☐Burning

☐Dribbling when Sneezing ☐Blood in Urine ☐Kidney Stone(s) ☐Urinary Tract Infection(s)

Other_____

Women:
Are you currently pregnant? Yes / No Are you presently trying to get pregnant? Yes / No

At what age did you start menstruating? _____ Number of days between cycles_____

Number of days of flow_____ Color _____

I have or had (check all that apply): ☐Irregular Menstruation ☐Heavy Flow ☐Light Flow ☐No Flow ☐Clots

☐Vaginal Itching/Burning ☐Spotting Between Periods ☐Discomfort/Pain Before Period ☐Discomfort/Pain During Period

☐Other_____ Any Vaginal Discharge? Yes / No Color_____

Men:
I have (check all that apply): ☐Prostatitis ☐Impotence ☐Penis Blood/Mucous Discharge

☐Other_____

Muscles, Joints & Bones:
Do you have pain or tightness? Yes / No Where?_____ The pain is (check all that apply):

☐Sharp ☐Dull ☐Aching ☐Numb ☐Superficial ☐Deep ☐Burning ☐Tingling ☐Shooting

☐Pain Worse/Better with Heat ☐Pain Worse/Better with Cold ☐Pain Worse/Better with Pressure ☐Pain Worse in AM/PM

I have (check all that apply): ☐Swollen Joints ☐Arthritis/Joint Pain ☐Tendonitis ☐Bone Pain

☐Muscle Cramping ☐Muscle Pain ☐Repetitive Strain Injury ☐Fractured Bone(s) Where?_____

☐Other_____

Eyes, Ears, Nose, Throat, & Head:
Do you smoke? Yes / No _____per day, for _____years

I have (check all that apply): ☐Frequent Colds ☐Chronic Runny Nose ☐Frequent Sore Throats ☐Chronic Cough

☐Coughing Blood ☐Coughing Mucous ☐Pain Inhaling ☐Shortness of Breath on Exertion/at Rest ☐Asthma

☐Nose Bleeds ☐Painful/Red Eyes ☐Poor Vision ☐See Spots/Floaters ☐Dizziness ☐Cold Sores ☐Bleeding Gums

☐Dry Mouth ☐Ear Pain ☐Ringing in Ears ☐Clogged/Popping in Ears ☐Frequent Headaches/Migraines:

Describe_____

Cardiovascular:
I have (check all that apply): ☐Chest Pain ☐Palpitation ☐Varicose Veins ☐Phlebitis

☐Cold Hands and Feet ☐Irregular Heart Beat ☐Poor Circulation ☐Other_____

Skin & Hair:
I have or often have (check all that apply): ☐Dry Skin ☐Skin Rashes ☐Itching ☐Acne ☐Eczema

☐Hives ☐Hair Loss ☐Premature Graying ☐Other_____

TREATMENT INFORMATION AND INFORMED CONSENT

Please take time to read this form, which will provide you with some basic knowledge about acupuncture and/or physical therapy treatment.

Acupuncture is performed by the insertion of pre-sterilized, disposable acupuncture needles through the skin, and/or the application of heat or electrical stimulation to certain points on the body. Your acupuncture treatment may be combined with physical therapy. It may also be combined with tui-na/acupressure, Chinese herbs, moxibustion, cupping, electric stimulation, infrared heat lamp, and/or therapeutic exercises based on the fundamentals of Chinese Medicine. Your practitioner will explain the nature of each type of treatment as needed.

Other important things to keep in mind regarding acupuncture treatment:

- While the needles are in place, do not change your position or move suddenly.
- Wear comfortable, loose clothing.
- Maintain good personal hygiene.
- Avoid treatment when excessively fatigued, hungry, full, or emotionally upset.
- We are unable to treat patients who are intoxicated and /or are abusing substances.

Acupuncture is generally very safe. Although rare, certain side effects may result from acupuncture and each procedure or treatment has specific risks and benefits. While receiving acupuncture treatment, please feel free to communicate with your practitioner what you experience during the needling process, as this will enable the practitioner to adjust needles and the points selected to maximize your comfort during the treatment. If you experience dizziness, nausea, a cold sweat, shortness of breath, or faintness during treatment, please let the practitioner know immediately. This is known as needle shock, and while its occurrence is extremely rare, it helps to let the practitioner know if you experience any of these symptoms so that the needles can be removed. These symptoms go away immediately after needles are withdrawn, and are generally caused by anxiety when receiving acupuncture for the first time. Other possible side effects of acupuncture treatment may include local bruising, mild pain in the area treated, brief generalized fatigue, tingling or numbness. Other potential risks from acupuncture are very rare. These risks include infection, bleeding, or pneumothorax (e.g. collapsed lung). We only use sterile needles one time, so the risk of infection is minimal and extremely rare. It is important that you advise the acupuncturist if you are on any blood thinning medication.

Physical therapy is performed by exercising, massaging, and/or applying heat to certain points of the body. Your physical therapy treatment may be combined with acupuncture. The Physical Therapist works to identify, prevent, improve, and/or restructure movement dysfunction. Holistic physical therapy treats the mind and the body. Rather than treating the conditions as dissected parts, the body is treated as a complete system – very much like the concepts of Oriental Medicine. We treat patients with deficits in range of motion, strength, endurance, and function due to musculoskeletal, cardiovascular or neurological involvement.

Please inform your practitioner if you have any of the following conditions:

- If you are pregnant and/or breastfeeding
- If you have ever experienced seizures, fainting or panic attacks
- If you have a pacemaker or any other electrical implants
- If you have HIV/AIDS, hepatitis or a sexually transmitted disease

Everyone responds to treatment differently therefore, we cannot guarantee the outcome. Some individuals experience total or partial relief of their pain or symptoms after the first few treatments. Others notice steady, gradual improvement. In some cases, no relief is felt at all until after several days. Occasionally, some people notice that their pain actually seems to be worse before it gets better. Let us know how you responded to the previous treatment at the time of your follow-up visit(s), so that your treatment plan can be adjusted accordingly. Depending on your condition and your goal for treatment, we may require a physician referral in order for you to continue treatment in our clinic. In addition, clients are responsible for seeking the advice and treatment of a physician should their symptoms change, or if any new condition(s) arise.

The Notice of Privacy Practice, which describes how we may use and disclose your protected health information, is available upon request.

By signing this informed consent, you (the patient) acknowledge that you have read the information above carefully and are giving consent for treatment.

_____Date_____ _____Date_____

Signature of Patient or Guardian if patient is a minor. *Signature of Witness*

I have read and understand the above statement.

AUTHORIZATION AND AGREEMENT

Please carefully read the agreements with **Health in Motion, LLC.**

FINANCIAL RESPONSIBILITY

Fees for Outpatient Services are due at the time of your appointment, before your services begin.

RETURNED CHECKS:

In the event your check does not clear, you will be charged a $30 administrative fee.

INITIAL _____

LATE FEES:

If you carry a balance with Health in Motion 30 days past the unpaid date of service, $10 will be added to your total balance. If this balance is still unpaid 60 days past said date of service, an additional $20 will be added to your total balance. If Health in Motion still does not receive payment by 90 days past the unpaid date of service, your account will be sent to collections.

INITIAL _____

CANCELLATION POLICY

An appointment at Health in Motion is a commitment between you and your practitioner. We aim to provide the pinnacle of holistic healthcare to as many patients seeking this type of treatment as possible. So, we request that you acknowledge and respect our time and our cancellation policy.

If you are running **more than 5 minute late**, please call us in advance to see if we are still able to treat you. If you are unable to keep a scheduled appointment, you must give at least **24 hours advanced notice**. If you miss your appointment due to tardiness or without providing proper 24 hour notification, you will be subject to a **cancellation fee of $40**.

INITIAL _____

RELEASE OF INFORMATION

I authorize **Health in Motion** to release information about me to the medical insurance company and/or referring physician. This authorization will end if I give written instructions to **Health in Motion**, which I may do at any time.

DISCLAIMER: In an attempt to provide quality customer service to our patients, any verification of your insurance is only an estimate and is not a guarantee of payment by your insurance company. Any insurance approval implied or otherwise is subject to all plan provisions in force at the time services are rendered. As a result, you, the patient will be held responsible for all fees incurred.

_____ _____

Patient or Guardian Signature Date

IN AND OUT OF NETWORK MEDICAL INSURANCE CLAIMS AGREEMENT

Please take time to read this form, which will provide you with some basic information regarding the submission of claims to in and out of network insurance carriers.

At the time we verify your insurance coverage, the information we give you is the information given to us by your insurance representative. However, any information we receive for that purpose is **not a guarantee of payment** and does **not guarantee coverage and/or reimbursement** by your insurer. Your insurer reserves the right to deny claims based on their definitions of medical necessity specific to the terms of your coverage. In the event of a claim denial you will be responsible for any unpaid balance by your insurance company. It is also understood that it is your responsibility to update **Health in Motion** with any changes in insurance coverage that may occur during treatment with this office.

INITIAL _____

Out of Network Only: Should your insurance carrier deny a submitted claim you submit for reimbursement, it is your responsibility to follow up with your carrier to receive payment. We can provide you with supporting documentation, however as we are an out of network provider, we cannot initiate appeals of denials.

INITIAL _____

Direct Billing: If Health in Motion bills your insurance company directly for your treatment, it will be your responsibility to endorse any payments which you receive from your insurance company to "Health in Motion". Please endorse the check, and write 'Payable to Health in Motion' under your signature.

INITIAL _____

By signing this form, you acknowledge that you have read the information above carefully and understand that coverage from your insurer is not guaranteed on the basis of your insurance verification through this office. Further, you acknowledge that you are seeking treatment for acupuncture and/or physical therapy and are aware the insurance carrier can at any time deny your claim according to the specifics of your policy and their regulations, regardless of the information we have been given at the time of verification.

In summary, the information given to us by the insurance representative is not a guarantee of payment and the insurer has the right to deny claims as per their policies. In the event your claim is denied, you agree to contact your insurer directly to resolve the issue. Health in Motion is not responsible for any claim denials through out of network submissions.

I have read and understand the above statement.

_____ _____

Signature of Patient Date