JOYCE LEUNG LILLY ACUPUNCTURE

NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION					
Patient's Last Name: First:		Middle:		Gender:	Birth date: / /
Street address:		Mobile phone no.: ( )			Age:
City:	State:			Zip Code:	Height:
	Email Address:				Weight:
Whom may we thank for referring you? ❑ Dr. _____ ❑ Insurance Plan ❑ Family ❑ Friend ❑ Web search ❑ Other					
Referral Patients (please check): If you have been referred by a medical practitioner, may I share your outcomes with them? ❑ Yes ❑ No					

INSURANCE INFORMATION					
Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance ❑ BCBS ❑ Empire ❑ United Healthcare ❑ Cigna ❑ Aetna ❑ HIP ❑ GHI ❑ No Fault ❑ Other					
Subscriber's name:	Subscriber's ID no.:	Birth date: / /	Group no.:		Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:		Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Mobile phone no.: ( )	Email:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Joyce Acupuncture NYC, PC or insurance company to release any information required to process my claims.

Patient Signature *Date*

Joyce leung Lilly Acupuncture, pc
190 South plank road,unit 9, newburgh, ny 12550
hello@joycelillyacupuncture.com 646.827.1128

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MEDICATIONS & ALLERGIES	
List current medications & purpose (including non-prescription):	
List any allergies:	

CURRENT MEDICAL CONDITIONS					
Please indicate if positive for:	❑ Pregnancy	❑ HIV	❑ Hepatitis	❑ Diabetes	❑ Seizures
	❑ Metal implants	❑ Blood-thinning medications	❑ High Blood Pressure	❑ Pacemaker	❑ Other

What are your primary concerns for coming in for acupuncture?	How long have you had this condition?
1.	
2.	
3.	
4.	
5.	

Pain quality feels:	❑ Sharp	❑ Burning	❑ Dull	❑ Cramping	❑ Tingling
	❑ Stabbing	❑ Shooting	❑ Aching	❑ Throbbing	❑ Moving

Is the pain:	❑ Fixed	❑ Moving	❑ Constant	❑ Cramping	❑ Intermittent

Pain **improved** with:	❑ Pressure	❑ Stretching	❑ Exercise	❑ Cold	❑ Heat
Pain **worse** with:	❑ Pressure	❑ Stretching	❑ Exercise	❑ Cold	❑ Heat

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ADVISORY TO CONSULT PHYSICIAN & CONSENT TO ACUPUNCTURE

Joyce Lilly Acupuncture is committed to your health and well-being. While Chinese Medicine has much to offer, it cannot replace the resources available through our Biomedical experts. There is, after all, a place for all things to exist in harmony. Therefore, it is recommended that you also consult your Physician regarding any condition for which you are seeking help through Acupuncture and Chinese Medicine.

To comply with Article 160, Section 8211.1 [b] of NYS Education law, it is requested that you read and sign the following statement:

- I, undersigned, do affirm that I have been advised by Joyce Leung Lilly Acupuncture to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

- I, hereby, request and consent to receiving Acupuncture treatments and other related procedures within the scope of practice of Acupuncture and Chinese Medicine by the acupuncturist indicated below. I understand that methods of treatment may include, but are not limited to: Acupuncture, Cupping, Gua-sha, Electrical Stimulation, Myofascial manipulation, Chinese herbal medicine, and Nutritional counseling.

- I understand that Acupuncture is a generally safe method of treatment, but that there may be some minor side effects – such as local bruising, a sensation of warmth, numbness or tingling in the area of the inserted needles. The effects may last a few minutes to a few days, depending on the person. There may also be a sensation of dizziness and fainting in rare cases. Please remember to have a small meal an hour before your visits, and be well hydrated to reduce the above mentioned effects.

- By signing below, I show that I have read and understand that it is recommended that I consult a physician for my condition(s) that I am seeking acupuncture for, and that I voluntarily consent to receiving acupuncture treatments.

Printed Name Signature Date

Acupuncturist Signature Date

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INSURANCE AGREEMENT

Insurance Coverage,

- If you have The Empire Plan, Blue Cross Blue Shield, Aetna, Cigna or United Healthcare, your plan may include acupuncture benefits. I will gladly go over your policy with you so you understand exactly what your benefits are & whether you have any deductibles to satisfy before any acupuncture services are covered.

Assignment of Benefits

- By signing this form, you are authorizing that payment of medical benefits be made directly to this office.
- If your insurance company (mostly The Empire Plan & Blue Cross Blue Shield) sends payment to you for services incurred in this office, you agree to endorse and send/bring those payments to me upon receipt.
- In the event that your health insurance policy does not cover the services incurred, you agree to pay for such services in addition to any co-payments, deductibles, & coinsurances as required by your policy.

Release of Information:

- By signing this form, you are authorizing release of any information concerning your health care, advice & treatment provided for the purpose of evaluating & administrating claims for insurance benefits.

Printed Name Signature Date

_____

Acupuncturist Signature Date

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FINANCIAL AGREEMENT

Payment Arrangements:

- All payments for office visits are due at the time of service.
- All home visits are to be paid in full before the appointment.
- For those paying by medical insurance, the deductibles typically reset at the start of each calendar year. Please note that it is your responsibility to satisfy your annual deductible before the insurance starts paying for services.

Insurance Patients:

- Many insurance policies currently cover acupuncture care, I am happy to verify your insurance information for possible coverage.
- Insurance policies may vary greatly in terms of deductibles & percentage of coverage for acupuncture care. All deductibles must be satisfied first before insurance coverage can be activated.
- Patients pay full office visit fees until deductibles are met.
- For your convenience, I will submit claims directly to your insurance company for processing.
- After deductibles are met, patient will pay only the 'Co-pay' rate indicated on your insurance policy card.
- If your insurance only covers a percentage of the total cost of treatment, you will be responsible for the balance (co-insurance) at the time of service.

Methods of payment:

- Preferred payment is Cash, Zelle or Venmo.
- Credit cards, HSA/FSA cards are accepted, but are subject to standard 4% swipe fee.

Printed Name Signature Date

Acupuncturist Signature Date

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CANCELLATION POLICY

- Please honor your appointment by being on time. Cancellations must be made before 24 hours of the appointment.
- For cash, credit card & insurance patients, please note you will be charged $130 for each no show.
- Prepaid package patients will lose one visit for each no show.

- Joyce Lilly Acupuncture is very strict about this policy as it helps to serve you and other patients better. In order to schedule any appointments, all clients must provide a credit card number to be kept securely on file. In the event of a late cancellation, your credit card will be charged for the cost of your session.

Please enter your credit card information below:

Name on Card: _____

Card#: _____

Expiration Date: _____ CVC: _____

Billing Zip Code: _____

I ascertain that I have read and fully understand the payment arrangements & cancellation policy.

Printed Name Signature Date

_____

Acupuncturist Signature Date

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Patient Name: _____

- Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever at or greater than 100 degrees Fahrenheit?

- Have you or anyone in your household been tested for COVID-19?

- Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?

- Have you or anyone in your household traveled in the U.S. in the past 21 days?

- Have you or anyone in your household traveled on a cruise ship in the last 21 days?

- Are you or anyone in your household a health care provider or emergency responder?

- Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19?

- Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19?

- To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19?

_____ _____

Signature of Patient Date

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NOTICE OF COVID-19

The Coronavirus / COVID-19 has been declared a worldwide pandemic by the World Health Organization (WHO). COVID-19 is extremely contagious and is believed to spread mainly from close proximity, person-to-person exchange, as well as by touching surfaces where an infected person has previously touched or dispersed bodily fluids on. As a result, federal, state and local governments, as well as federal and state health agencies recommend social distancing and have prohibited the congregation of groups of people.

Joyce Leung Lilly Acupuncture has put into place preventative measures to reduce the spread of COVID-19; however, there is no guarantee that you will not become infected with COVID-19.

ASSUMPTION OF RISK & WAIVER OF LIABILITY RELATING TO COVID-19

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to, or be infected with, COVID-19. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury, including personal injury, illness, permanent disability or even death linked with COVID-19.

I hearby release, covenant not to sue, discharge, and hold harmless, the office of Joyce Leung Lilly Acupuncture, as well as the leasing office of Integrative Healing Arts, and their representatives, of and from the Claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of relating thereto. I understand and agree that this release includes any Claims based on the actions, omissions, or negligence of the Office, its employees and representatives, whether COVID-19 infection occurs before, during, or after your office visits at: 190 South Plank Road, Newburgh, NY.

_____ _____

Signature of Patient Date

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