Wellstream
Healing & Acupuncture

Sarina T. Hrubesch, AP, DiplOM
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'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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COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

NOTE: All information is strictly confidential pursuant to HIPAA regulations.

Primary Complaint: _____

_____

How long have you had problem? _____ Have you had this in the past? _____

How does this problem interfere with your daily activities? _____

_____

What makes it better? _____ What makes it worse? _____

_____ _____

Is your condition: ☐ Constant ☐ Intermittent Pain Level: ☐ Low ☐ Slight ☐ Moderate ☐ Severe

Secondary Complaint: _____

Other concurrent therapies: _____

How are you responding to your present course of treatment? ☐ Better ☐ Worse ☐ Same

Surgeries/Hospitalization (please include dates):

_____

_____

Significant Trauma/Accidents: _____

Do you have: ☐ Pacemaker ☐ Metal Implants **Are you or might you be pregnant?** ☐ Yes ☐ No

Allergies: _____

Medications (INCLUDING vitamins, supplements, herbs):
If you need more room, please use the back of this page.

Name	Dosage	Purpose

Stress: ☐ None ☐ Low ☐ Moderate ☐ Severe Explain Causes: _____

_____

Exercise (type/frequency): _____

Habits: ☐ Cigarettes ☐ Coffee ☐ Tea ☐ Sodas ☐ Alcohol ☐ Drugs _____

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Do you: ☐ Skip meals ☐ Snack ☐ Eat large meals ☐ Eat when rushed ☐ Work and eat ☐ Eat but not hungry

Average Daily Diet:

AM _____

Afternoon _____

PM _____

Snacks _____

YOUR MEDICAL HISTORY:

☐ Cancer ☐ HIV+ ☐ Diabetes ☐ Heart Disease ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Stroke

☐ Epilepsy ☐ Asthma ☐ Kidney Disease ☐ Anemia ☐ Bleeding Disorder ☐ Allergies ☐ Ulcers ☐ Gout

☐ STD ☐ Herpes ☐ Hepatitis ☐ Jaundice ☐ Thyroid Disease ☐ Autoimmune Disease (type) _____

☐ Chronic Fatigue ☐ Sudden Weight Loss ☐ Sudden Weight Gain ☐Alcoholism ☐ Emphysema

Other _____

Dates of Illness: _____

FAMILY MEDICAL HISTORY: Current or past conditions

Mother _____

Father _____

Other close relatives _____

For the following Organ Systems Evaluation Sections,
please check any problems that are frequent, or that have occurred recently

MUSCULOSKELETAL PAIN

□ Neck □ Back □ Knee □ Shoulder □ Wrist □ Hand □ Ankle □ Foot □ Hip □ Fingers □ Toes
□ Other area _____ □ Bones sore/painful □ Loss of Grip □ Swollen Joints □ Weakness
□ Leg cramps at night □ Tingling in feet □ Loss of feeling in hands/feet □ Muscle spasm/cramps
□ Stiffness all over □ Osteo-Arthritis □ Rheumatoid Arthritis □ Tendinitis □ Sciatica

Onset of Pain: _____ Better with? _____ Worse with? _____
Describe the pain (burning/constant/intermittent/pins&needles/numbness/coldness/sharp/dull)

_____

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HEAD, EYES, EARS, NOSE AND THROAT

□ Dizziness □ Concussion □ Poor Memory □ Loss of Balance □ Head feels 'Heavy' □ Migraines

□ Headaches (describe) _____

□ Eye Strain □ Eye Pain □ Floaters □ Blurred Vision □ Dry Eyes □ Watery Eyes □ Itchy Eyes
□ Ear Ache □ Ear Infections □ Hearing Loss □ Ringing/Buzzing in Ears □ Grinding Teeth □ TMJ
□ Teeth Problems □ Facial Pain □ Facial Paralysis □ Sensation of 'Lump' in Throat
□ Sinus Problems □ Mucus □ Nose Bleeds □ Runny Nose □ Congestion □ Frequent Colds
□ Sore Throat □ Copious Saliva □ Dry Mouth □ Difficulty Swallowing □ Hoarseness/Loss of Voice

LUNG SYSTEM

□ Shortness of Breath □ Difficulty Breathing □ Wheezing □ Cough □ Asthma □ Bronchitis
□ Pneumonia □ Difficulty Breathing When Lying Down □ Coughing Blood □ Coughing Phlegm
Sputum color? _____ Thick or Thin? _____ Other?_____

HEART SYSTEM

□ Heavy Sleep □ Insomnia □ Wake Easily □ Nightmares □ Difficulty falling asleep □ Difficulty staying asleep
□ Wakes frequently □ Wakes early; Time? _____ □ Restless □ Sleep Soundly □ Night sweating
□ Snoring □ Sleep Apnea
□ Cold Feet □ Cold Hands □ Swollen Hands/Feet □ Cold Back □ Localized Weakness
□ Fevers □ Chills □ Tremors □ Vertigo □ Dizziness □ Fainting □ Fatigue
□ High Blood Pressure □ Low Blood Pressure □ Pain/Pressure Chest □ Irregular Heart Beat □ Palpitations

SKIN/HAIR

□ Rashes □ Eczema □ Hives □ Itching □ Purpura □ Dryness □ Clammy/Moist □ Burning
□ Changes in Moles or Lumps □ Bleeds/Bruises Easily □ Varicose/Spider Veins □ Hair Loss □ Dry Scalp
□ Change in Hair Texture □ Scars
Other _____

DIGESTIVE SYSTEM

□ Poor Appetite □ Excess Hunger □ Feel tired if miss meal □ Cold Abdomen □ Weight Gain □ Weight Loss
□ Strong Thirst □ For cold? □ For hot? □ Never thirsty □ Crave Sweets □ Crave Salty □ Crave Sour

Specific food craving? _____ Peculiar Tastes or Smells? _____
□ Heartburn □ Nausea □ Vomiting □ Belching □ Abdominal Bloating □ Foul Breath □ Stomach Pain
□ Diarrhea □ Constipation □ Flatulence □ Hemorrhoids □ Black Stools □ Bloody Stools □ Mucous Stools
□ Pain/Cramps □ Sensitive Abdomen □ Foul Odor □ Colitis □ Irritable Bowel
□ Sudden Energy Drop At _____(time) □ Fatigue □ Restless □ Energetic □ Heavy Limbs □ Weak Limbs

GENITO-URINARY

□ Pain/burning with Urination □ Pain before Urination □ Urgency to Urinate □ Incontinence □ Blood in Urine
□ Kidney Stones □ Frequent Infections □ Strong urine smell □ Incomplete Urination □ Urgent Urination
□ Frequent Urination: □ Day □ Night

(For Men) □ Prostate Enlarged □ Elevated PSA □ Impotence □ Premature Ejaculation □ Nocturnal Emission
□ Pain/Itching of genitalia □ Lumps in testicles □ Increased Libido □ Decreased Libido

Other_____

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GYNECOLOGY (For Women)
□ Pregnant? # of Pregnancies____ # of Deliveries ____ # Miscarriages _____ # of Abortions _____
Age Started menstrual cycle _____ Age Stopped _____ Last Monthly Period _____
Period
Duration _____ Birth Control Method_____ Last PAP? _____
□ Heavy Flow □ Light Flow Color (pale/dark/red/purple?) _____
□ Irregular Periods □ Scanty Periods □ Missed Periods □ Painful Periods □ Clots □ Cramps □ Spotting
□ Vaginal Discharges: □Yellow □ White □ Thick □ Thin □ Itching □ Odor
□ Breast Lumps □ Breast Pain □ Menopause □ PMS □ Fibroids □ Endometriosis □ Low Libido
□ Low Backache □ Water Retention □ Hot Flashes
□ Other _____

EMOTIONAL & NEUROLOGICAL
□ Seizures □ Tremors □ Numbness/Tingling □ Tics □ Always Cold □ Always Hot □ Poor Coordination
□ Neuralgia (pain) □ Shingles □ Other _____
□ Nervousness □ Depressed □ Anxiety/Worry □ Easily Angered □ Easily Irritated □ Stressed
□ Giddy □ Sadness/Grief □ Frequent Crying □ Mood Swings □ Suicidal □ Phobias/Fears □ Manic
□ Panic Attacks □ Indecisive □ Other Emotional_____

Thank you for completing this confidential, medical history questionnaire. Your honest, complete answers will assist me in providing you with the best possible health care.

Most Favorite:
Climate (dry/wet) _____
Season _____
Temperature _____
Taste _____
Food _____
Time of Day _____
Color _____

Least Favorite:
Climate (dry/wet) _____
Season _____
Temperature _____
Taste _____
Food _____
Time of Day _____
Color _____

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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 (Oriental massage), Oriental herbal medicine, and nutritional 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 and 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 Oriental 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, LLC
Acupuncturist: Sarina T. Hrubesch, AP, DiplOM FL License AP3860

Patient signature: _____ Date: _____

OR

Patient Representative: _____ Date: _____
(indicate relationship to patient)

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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, LLC 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, LLC has a Notice of Privacy Practices and that the Patient has the opportunity to review this Notice
- Wellstream, LLC reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information but Wellstream, LLC 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, LLC 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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PATIENT CARE FINANCIAL AGREEMENT POLICY

Effective June 1, 2019

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 cash, 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. We will provide a superbill for services rendered. The full cost of services is your responsibility; payment is due promptly at time of service.
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: _____