INTEGRAMED HEALING ARTS
MARTIN M. SILBER, L.Ac.
COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

I AGREE TO RECEIVE TREATMENT CARE FROM/BY INTEGRAMED HEALING ARTS and MARTIN M. SILBER, L.Ac., and I confirm and understand the following by my initials in all 7 places provided below.

I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to- person contact, in which COVID-19 can be transmitted. _____

I understand that I am opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives to receiving this care, which could include receiving care from another type of provider, or postponing care altogether at this time. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____

I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office. _____

I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below:

*Fever	*Dry Cough	*Sore Throat
*Shortness of Breath	*Runny Nose	*Loss of Taste or Smell _____

I understand that travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that in the past 14 days I HAVE NOT TRAVELLED:
1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____

I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____

I have been offered a copy of this consent form. _____

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PATIENT INFORMATION

Date_____

Name_____

Address_____

_____
City State Zip

Sex ☐M ☐F Age_____Birthdate_____

☐Single ☐Married ☐Significant Other
☐Widowed ☐Separated ☐Divorced

Patient SS#_____

Occupation_____

Employer_____

Emp.Address_____

Emp.Phone_____

Spouse/Partner's Name_____

Birthdate_____SS#_____

Occupation_____

Spouse/Partner's Employer_____

Whom may we thank for referring you?_____

PHONE NUMBERS

H_____W_____Cell_____

Best time & place to reach you_____

IN CASE OF EMERGENCY, CONTACT

Name _____Relationship_____

Home Phone_____Work Phone_____

INSURANCE

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Policy #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Policy #_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent have insurance coverage with_____and assign directly to _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the provider to release all information necessary to secure the payment of bef benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date_____

Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident?

☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other

Attorney Name (if applicable)_____

GENERAL INFORMATION

Have you had acupuncture before? ☐ Yes ☐ No Have you used Chinese herbal medicine? ☐ Yes ☐ No

Are you currently under the care of a physician? ☐ Yes ☐ No If Yes, for what? _____

Physician's name:_____ Physician's phone:_____

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Statement of Informed Consent

We, the undersigned, do affirm that _____ (The Patient) has been advised by, IntegraMed Inc. and the undersigned licensed professional(s) to consult a physician, if they have not already, regarding the condition(s) for which such patient is seeking therapy.

The Patient agrees to willfully and truthfully divulge all pertinent information, medications and modalities used, etc., regarding the condition(s) in order to better assist IntegraMed Inc. and the undersigned licensed professional(s).

Because the nature of needles, moxabustion, and herbal remedies may cause some bleeding, bruising, burns and in the case of herbs and hypnosis, stomach upset and disorientation, The Patient, having been forewarned, accepts these as an integral part of the treatment and agrees to hold harmless, IntegraMed Inc. and its employees from any complication(s) which may occur as a result.

The undersigned licensed professional(s) and IntegraMed Inc. offers no guarantees, implied or written, as to the effectiveness in treating the condition(s) for which such Patient seeks treatment. The undersigned Patient clearly understands this agreement and willfully consents to receive service.

_____

Patient's name (please print) Patient's Signature and date

_____

Therapist's name Therapist's Signature and date

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WORKING WITH YOUR INSURANCE COMPANY

Compliance with your insurance company and their guidelines can be most important. Since every insurance plan has its own special requirements, it is impossible for us to be familiar with each and every plan, It is your responsibility as the patient to be familiar with your individual coverage. We will be happy to complete all of the necessary forms to submit to your insurance company, along with any required documentation.

It is important for you to become an informed consumer relative to your insurance coverage. If your insurance company requires pre-certification, pre-authorization or referrals for services, it is your responsibility to obtain those authorizations and to notify the doctor.

If there is a change in the status of your insurance coverage (insurance company changes, plan changes, or a loss of coverage) you must notify us immediately. You will be responsible for any and all charges incurred at this time. Failure to notify us could result in an outstanding balance charged to you.

Please contact us if you have any questions about pre-certification or about your statement, and please always feel free to discuss your concerns directly with the doctor.

We are here for you, and it is always our pleasure to be of service.

Signature of Patient Date

Signature of Witness Date

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ATTENDANCE POLICY
FOR INITIAL CONSULTATION AND FOLLOW-UP VISITS

• If you are unable to keep an appointment, please have the courtesy to cancel as far in advance as possible. We are aware that last minute cancellations are sometimes necessary; however we woud like you to inform us as soon as possible about your need to cancel.

• There is ***Rarely*** an excuse for not showing up for a scheduled appointment without the courtesy of a phone call. Not attending a scheduled appointment is unacceptable and is disrespectful to our office.

• **Please be advised that we charge a $25.00 fee for each missed appointment.** Missed appointment fees will not be covered by your insurance company. Currently we do not impose a charge if we are notified at least 24 hours prior to your appointment about a cancellation. We would request that if you will not be able to keep your appointment, you inform us as soon as possible.

• *If you are calling to cancel or reschedule an appointment:* ***516-932-6702****.*

I have reviewed and understand the "Attendance" policy:

Name of Patient (print) Signature of Patient Date

Name of Witness(Print) Signature of Witness Date

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Present Health Concerns: Please list your most important health concerns in order of significance.

1. _____ Approx Date of Onset: _____
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Other therapies tried: ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Phys Therapy ☐ Other _____

2. _____ Approx Date of Onset: _____
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Other therapies tried: ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Phys Therapy ☐ Other _____

3. _____ Approx Date of Onset: _____
Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Other therapies tried: ☐ Medications ☐ Surgery ☐ Chiropractic ☐ Phys Therapy ☐ Other _____

Please list all **medications** that you are currently taking (or have used in the past two months), with dosages:

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Please list all **vitamins, minerals, herbs, or homeopathic remedies** that you are currently taking:

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

Please list **allergies** that you have to any of the following:

Drugs: _____ Foods: _____

Others (i.e. pollen, paint, etc.): _____

HEALTH HISTORY

Past Medical History: Please list past injuries, broken bones, surgeries and hospitalizations, with approx dates.

_____

_____

_____

Personal Habits:
☐ Tobacco packs/day _____
☐ Alcohol drinks/day _____
☐ Coffee/Tea/Cola cups/day _____
☐ Recreational drugs times/day _____

☐ High Stress Level Reason _____

Do you follow any diet regimens/restrictions?
☐ Yes ☐ No
If Yes, describe: _____

Work Activity:
☐ Sitting % of time _____
☐ Standing % of time _____
☐ Light Labor % of time _____
☐ Heavy Labor % of time _____

Exercise:
Do you exercise regularly? ☐ Yes ☐ No
If Yes, describe & tell how often: _____

_____

_____

FAMILY INFORMATION

Do you have children? ☐ Yes ☐ No If Yes, how many? _____ Ages _____

Please check if you have had (in the **last six months**)

GENERAL

- ❑ Poor appetite
- ❑ Heavy appetite
- ❑ Changes in appetite
- ❑ Weight loss/gain
- ❑ Cravings
- ❑ Peculiar tastes
- ❑ Strong thirst
- ❑ Fevers/Chills
- ❑ Sweat easily
- ❑ Localized weakness
- ❑ Bleed / bruise easily
- ❑ Sudden energy drop (time?)
- ❑ Fatigue
- ❑ Tremors
- ❑ Poor sleeping
- ❑ Heavy sleeping
- ❑ Dream disturbed sleep
- ❑ Night sweats
- ❑ Dizziness

SKIN AND HAIR

- ❑ Rashes/Hives
- ❑ Itching
- ❑ Dry skin
- ❑ Dandruff
- ❑ Ulcerations
- ❑ Eczema/Psoriasis
- ❑ Loss of hair
- ❑ Pimples/Acne
- ❑ Fungal infections
- ❑ Recent moles
- ❑ Change in hair or skin texture

Other hair or skin concerns:

HEAD, EYES, EARS, NOSE, AND THROAT

- ❑ Concussions
- ❑ Glasses/Contacts
- ❑ Eye strain/pain
- ❑ Red eyes
- ❑ Itchy eyes
- ❑ Dry eyes
- ❑ Excessive tearing
- ❑ Poor/blurry vision
- ❑ Night blindness
- ❑ Cataracts/Glaucoma
- ❑ Spots in front of eyes
- ❑ Earaches/Infections
- ❑ Ringing in ears
- ❑ Poor hearing
- ❑ Sinus problems
- ❑ Post nasal drip
- ❑ Excessive phlegm – color_____
- ❑ Nose bleeds
- ❑ Recurrent sore throats
- ❑ Swollen glands
- ❑ Sores on lips/tongue
- ❑ Dry mouth
- ❑ Excessive saliva
- ❑ Teeth problems
- ❑ Gum problems
- ❑ TMJ disorder
- ❑ Grinding teeth
- ❑ **Headaches** (location, triggers, severity)?

Other head & neck concerns:

CARDIOVASCULAR

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Palpitations
- ❑ Fainting
- ❑ Cold hands/feet
- ❑ Swelling of hands
- ❑ Swelling of feet
- ❑ Blood clots
- ❑ Phlebitis

Other heart or blood vessel concerns:

RESPIRATORY

- ❑ Cough
- ❑ Coughing blood
- ❑ Wheezing
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Pain with deep breath
- ❑ Shortness of breath
- ❑ Tight chest
- ❑ Production of phlegm - color?_____ Is it ☐thick or ☐thin

Other lung related concerns:

GASTROINTESTINAL

- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Hiccups
- ❑ Belching
- ❑ Bad breath
- ❑ Blood in stools
- ❑ Black stools
- ❑ Mucus in stools
- ❑ Acid Regurgitation
- ❑ Abdominal pain
- ❑ Itchy anus
- ❑ Burning anus
- ❑ Hemorrhoids/fissures

History of chronic laxative use?

Other concerns with your general digestion:

GENTIO-URINARY

- ❑ Pain on urination
- ❑ Frequent urination
- ❑ Blood in urine
- ❑ Urgency to urinate
- ❑ Unable to hold urine
- ❑ Decrease in flow
- ❑ Bedwetting
- ❑ Kidney stones
- ❑ Impotency
- ❑ Increased libido
- ❑ Decreased libido
- ❑ Premature ejaculation
- ❑ Nocturnal emissions
- ❑ Sores on genitals
- ❑ Frequent urinary tract infections
- ❑ Chronic yeast infection

If you wake to urinate, how often?

Other concerns with genitals or urinary system:

MUSCULOSKELETAL

- ❑ Neck pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Hand/wrist pains
- ❑ Muscle pains
- ❑ Muscle weakness
- ❑ Cramps/spasms
- ❑ General joint pain/stiffness
- ❑ Shoulder pain
- ❑ Knee pain
- ❑ Foot/ankle pain
- ❑ Hip pain
- ❑ Joint with limited range of motion_____

Other muscle, joint or bone concerns:

NEUROPSYCHOLOGICAL

- ❑ Seizures
- ❑ Loss of balance
- ❑ Areas of numbness
- ❑ Tics
- ❑ Lack of coordination
- ❑ Memory loss
- ❑ Concussion
- ❑ Depression
- ❑ Anxiety
- ❑ Irritability
- ❑ Easily susceptible to stress
- ❑ History of emotional/physical abuse

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other neurological or psychological concerns:

GYNECOLOGY

Age of first menses_____ If no longer menstruating, approximate date ceased_____

First day of last menses_____ Length between menses:_____days Duration of period:_____days

- ❑ Unusual flow (☐heavy or ☐light)
- ❑ Painful periods
- ❑ Irregular periods
- ❑ Clots in flow
- ❑ Vaginal discharge – color_____
- ❑ Vaginal odor
- ❑ Vaginal dryness
- ❑ Vaginal sores
- ❑ Hot flashes
- ❑ Breast lumps/soreness

GYNECOLOGY (continued)

Changes in body or psyche prior to menstruation ("PMS"):

Date of last PAP:_____ Results were: normal abnormal unsure
If you use birth control, what type & for how long?

Have you ever used hormonal methods for contraception or period regulation?
(i.e. the pill, Depo-Provera, etc.)

Other gynecological concerns:

PREGNANCY HISTORY

Are you, or could you be currently pregnant? Yes____ No____ Due Date_____

Number of pregnancies_____ Births_____ Miscarriages_____ Abortions____
Were your births relatively normal? Explain:
Other related concerns:

COMMENTS

Please let us know of any other concerns you would like to address:

FAMILY HISTORY: Please fill in the boxes for each condition that applies to one of your family members

	Yes	Who	Comments
Addiction (alcohol/drugs)			
Cancer			
Cardiac disorders (heart disease, high blood pressure, stroke)			
Diabetes			
Digestive/Gastro-intestinal disorders			
Immune disorders (hepatitis, HIV, etc.)			
Mental illness			
Respiratory disorders (asthma, allergies, etc)			
Skin disorders (eczema, psoriasis, etc.)			
Seizure disorders			

Signature: _____ Date: _____

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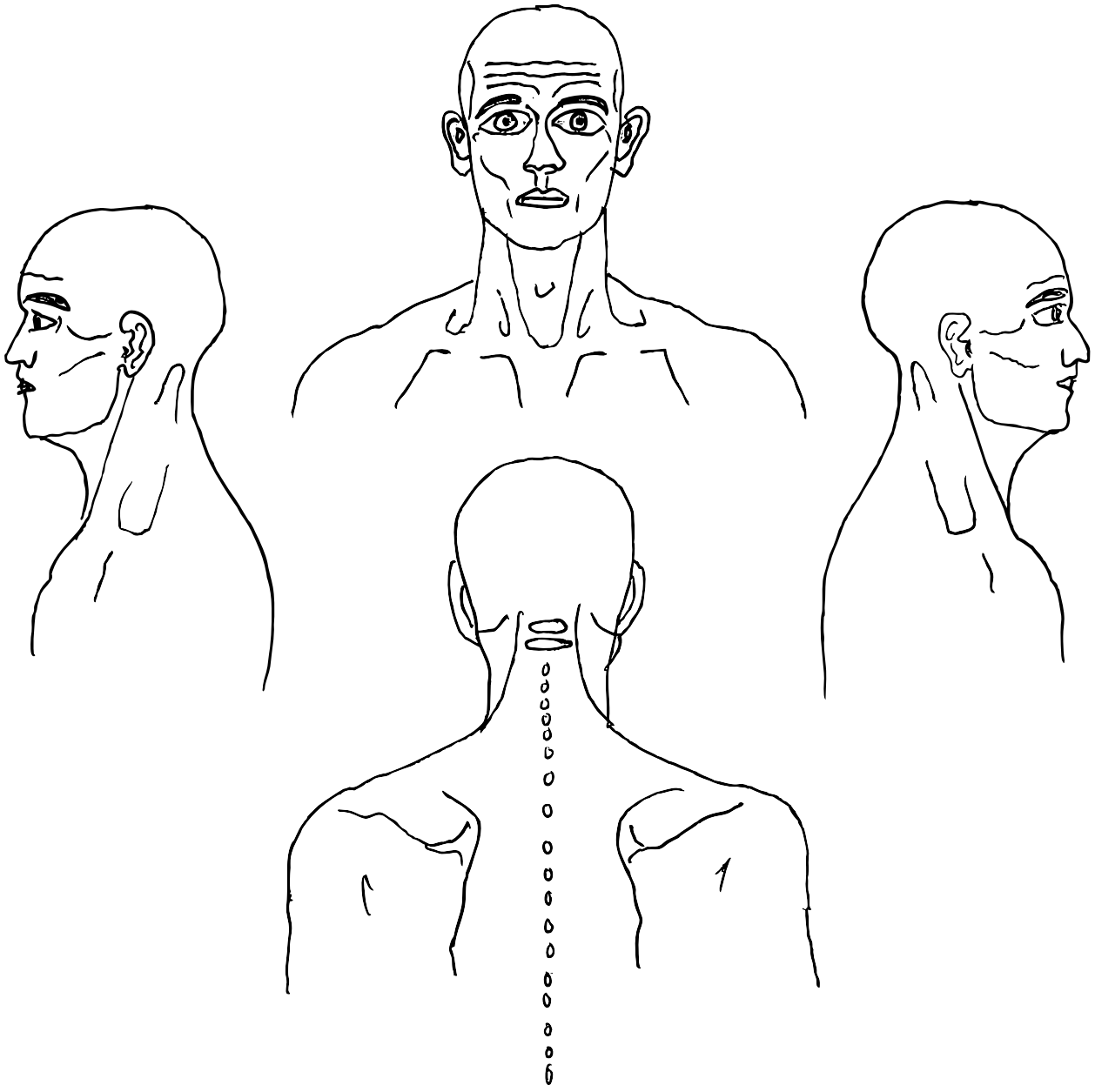
BY USING THE KEY BELOW, INDICATE ON THE BODY DIAGRAMS WHERE YOU ARE EXPERIENCING THE FOLLOWING SYMPTOMS.

N = NUMBNESS
B = BURNING
S = STABBING
P = PINS & NEEDLES
A = ACHING



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