Scholars Way Healing Arts

Acupuncture New Patient Intake Form

Today's Date_____

_____(____/____/____)_____

Name Date of Birth Age Height Weight

_____

Street Address Unit City State Zip

_____

Cell Phone Home Phone Email (for appt reminders and billing communication)

If you prefer not to receive text message appointment reminders, please check here: ( ). Opt-out of Text Message Reminders

Employer_____ Occupation_____

Emergency Contact_____ Relationship_____

Who can we thank for referring you to us?_____

Have you ever seen an Acupuncturist before? ◯ Yes ◯ No If yes, when?_____

If yes, who did you see?_____ What for?_____

Have you ever seen a chiropractor? ◯ Yes ◯ No Nutritionist? ◯ Yes ◯ No

PRIMARY CARE PHYSICIAN

Name_____ Hospital or Group associated w/:_____

Address_____ Phone_____

Did your primary care physician refer you to us? ◯ Yes ◯ No

Please list any other providers you have seen for your condition_____

May we communicate with your other physicians about your case and treatment? ◯ Yes ◯ No

Please feel free to list/describe any other issues you would like to discuss.

_____

Please list any vitamins, supplements, or herbal medicines you are currently taking (with dosage):

_____

Please list any allergies or adverse reactions, especially to food or drugs:

_____

MEDICAL HISTORY

Please check any of the following that have ever affected you.

☐ Addiction	☐ Cancer	☐ Fibromyalgia	☐ High Cholesterol	☐ Neuralgia	☐ Tuberculosis
☐ AIDS/HIV	☐ Candida	☐ Gallstones	☐ Hypertension	☐ Paralysis	☐ Ulcers
☐ Alcoholism	☐ Colitis/ bowel disease	☐ Glaucoma	☐ Hypotension	☐ Prostate problems	Others
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Kidney stones	☐ Rheumatism	Others
☐ Arteriosclerosis	☐ Digestive disorders	☐ Gout	☐ Malaria	☐ Seizures	Others
☐ Arthritis	☐ Eating disorder	☐ Heart disease	☐ Meningitis	☐ STD	Others
☐ Asthma	☐ Emotional imbalance	☐ Hernia	☐ Mononucleosis	☐ Stroke	Others
☐ Breast lumps	☐ Emphysema	☐ Hepatitis	☐ Multiple sclerosis	☐ Thyroid problems	Others
☐ Bursitis	☐ Epilepsy	☐ Herpes	☐ Nephritis	☐ Tonsillitis	Others

Surgeries, Hospitalizations, and Significant traumas (car accidents, loss of loved ones, etc.):

Date	Event

Medications taken in the last 3 months, including over-the counter medications:

Medication	Dosage	Reason	How long

The information on this form is correct and accurate to the best of my knowledge.

Print Name:_____

Signature:_____ Date:_____

Authorizations and Releases

By initialing and signing below, you agree to the following:

Patient Health Information and Privacy Policy

This policy outlines the way Patient Health Information (PHI) will be used in this office and the patient's rights concerning those records. You must read and consent to this policy before receiving services. A complete cop of the Health Information Portability and Accountability Act (HIPAA) is available here: http://wwwcms.hhs.gov/Securitystandard/Downloads/securitypropsedrule.pdf.

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limi the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their health records at any time and request corrections. The patient may request to know what disclosures have been made, and submit in writing any further restrictions on the use of their PHI. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care of services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations. Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures. Patients have the right to file a formal complaint with our privacy official about any suspected violation.
5. This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Initial_____

Consent to Professional Treatment

The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the acupuncturist. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, I hereby stipulate that I am the legal guardian of the child, and grant my consent for the treatment of the child as provided for herein. The patient may refuse treatment at any time.

Initial_____

Missed appointments&Late Cancellation Charges

Patient will be charged a $40 fee for missed appointments or appointments that are canceled less than 24 hours in advance of the scheduled start time.

Initial_____

Credit Card Charges

Payment of acupuncture services is due at the time of service. You authorize us to hare your credit or debit card on file for any balances on your account, and you authorize us to retain credit card, debit card, or other payment source information supplied by you for current and future charges.

Initial_____

Agreed and accepted:

Name (print):_____

Signature:_____ Date:_____