HANDS ON
ACUPUNCTURE & MASSAGE THERAPY P.C.

1239 N. Country Road, Suite 3, Stony Brook, NY 11790
www.HandsOnAcupuncture.com
631-601-6491

HEALTH HISTORY QUESTIONNAIRE

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. **All information is strictly confidential.**

Last Name: _____ First Name: _____ MI: ___

Guardian (if under 18): _____ Relation: _____ Date: __/__/___

Date of Birth: ___/___/____ Age: _____ Gender: ___M ___F

Weight: _____lbs. Height: _____'_____" Name Suffix: _____ Marital Status: _____

Address:_____

City: _____ State: _____ Zip: _____

Phone: Home: (___)_____ Cell: (___)_____Work: (___)_____ Ex._____

Fax: (___) _____ Preferred Contact # ___H ___C ___W___ Email ___Text

May we send you appointment reminders? __Y__N_ preferred method Email____Text___ Both___

Email Address: _____

Occupation: _____ Employer: _____ Employer City: _____

Emergency Contact: _____ Relation: _____ Phone #_____

Does anything limit you from care? __Yes __ No If yes, explain: _____

How did you hear about our office? _____

What is your primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

Does this interfere with your daily activities? __Y __N If yes, check all that apply.

__Work ___Sleep __Walking __Sitting __Bending __Stretching __Exercising __Emotionally __Relationships

__Social Life __Sexually __Recreation Other_____

What have you done about this? _____

What are your health goals? _____

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INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Co.: _____ What state are you insured in? _____

Primary Insured Information
DOB: _____/_____/_____
Last Name: _____ First Name: _____ MI: ____

Patient Information
Relationship To Primary Insured: _____
Patient Name: _____ Patient DOB: _____/_____/_____
Social Security no. _____
Subscriber ID: _____Group No.: _____
Plan Name: _____ Deductible: _____ Visit Co-payment: _____

SECONDARY INSURANCE

Insurance Co.: _____ What state are you insured in? _____

Primary Insured Information
DOB: _____/_____/_____
Last Name: _____ First Name: _____ MI: ____

Patient Information
Relationship To Primary Insured: _____
Patient Name: _____ Patient DOB: _____/_____/_____
Social Security no. _____
Subscriber ID: _____Group No.: _____
Plan Name: _____ Deductible: _____ Visit Co-payment: _____

Credit Card no. _____ Name on Card: _____
Card Expiry: _____/_____

We will verify coverage prior to treatment. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for each treatment until verification is obtained. Verification of coverage is not a guarantee of payment. Our fees are determined by the complexity of the particular care and the different services used during treatment. Any balance due on your treatments is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring all insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. If your insurance company has not paid your account in full within 60 days, the balance of your account will be billed to you directly (or automatically charged on your Credit Card). In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of the claim.

My signature below indicates that I understand and agree to these policies.

_____ Date: _____
Signature of Patient or Responsible Party

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NOTICE OF AUTHORIZATION OF INSURANCE BILLING

As a courtesy to our clients, our office has been helping the clients to bill the insurance. Our billing policy is as following:

1. Elizabeth Martin L.Ac, LMT is an out of network provider, our office only accepts PPO policies which cover Out-of-Network providers for acupuncture, only In Network with Cigna.
2. If you have no insurance coverage, we will give a cash discount.
3. If you do have insurance that covers acupuncture treatment or other modalities:

   A. As a courtesy, our office will bill your insurance for you at the full insurance fee rate. You will, however, be required to pay your initial treatment at the cash based rate until we receive the first reimbursement and/or your deductible is covered. After that time, you will be required to pay your insurance policies stated copay or coinsurance fee if required by your insurance, and/or the difference of the full insurance reimbursement and cash based fees. You will be reimbursed for the initial visits once we receive the full payment from your insurance provider, or, these funds can be applied to the cost future treatments.

   B. The insurance fees charged in this office are customary and reasonable based on industry standards and are comparable to those charged by other specialists with similar qualifications in this geographic area.

Please sign the following agreement to confirm that you understand our offices fees, insurance and billing policy. If your insurance is billed by our office, your billing statement will show "signature on file."

I, _____, have read and agree with the above statements. (please check one of the following)

____ I authorize Elizabeth Martin L.Ac, LMT of Hands On Acupuncture & Massage Therapy PC to bill my insurance

____ I choose not to have my insurance billed for me and will pay cash or credit card for my treatments at the time of service.

Your signature: _____ Date:_____

Provider: Elizabeth Martin L.Ac, LMT, Hands On Acupuncture & Massage Therapy PC

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HIPAA CONSENT FORM

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 the 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. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice 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.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:

PATIENT NAME (guardian if under 18 years):_____

PATIENT/GUARDIAN SIGNATURE:_____ DATE: _____

RELATIONSHIP TO PATIENT (if other than patient):_____

PRACTICE REPRESENTATIVE:_____

WITNESS SIGNATURE:_____ DATE: _____

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ACUPUNCTURE INFORMED CONSENT FORM

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 on the patient named below, for whom I am legally responsible) by the Acupuncturist indicated below and/or the Licensed Acupuncturists who now or in the future treat me while employed by, working 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 Simulation, Tui-Na (Chinese Massage), Chinese herbal medicine, NAET (Allergy Elimination), Medical Massage 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 be an 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 the 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. Burns and/or scarring are a potential risk of Moxibustion and Cupping, or when treatment involves the use of heat amps. Bruising is a common side effect of cupping. Unusual risks of Acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

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 Chinese 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 think 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 repots, but all my records will be kept confidential and will not be release without my written consent.

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.

ACUPUNCTURIST NAME: _____

PATIENT SIGNATURE: X _____
GUARDIAN SIGNATURE (if under 18 years old): X _____

DATE: _____

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CANCELLATION AND NO SHOW POLICY

The following are our policies regarding cancellations and no-shows. We take this subject seriously because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and or/your Acupuncturist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your Acupuncturist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hour notice in the event of a cancellation. When you call in, it is your responsibility to have an alternative date and time in mind. This will ensure that you get the full prescribed number of treatments for that week whenever possible.

- There is a charge of $25 for a cancellation without proper notice. This charge will not be covered by insurance and must be paid by you personally.

- Worker's Compensation and Personal Injury patients are hereby informed that documentation of any missed appointments is forwarded to the Case Manager and Primary Physician and could jeopardize your claim.

- When rescheduling a missed appointment, you may need to see a therapist who you have not seen before. Be assured that all of our therapists are experienced professionals, who will study your patient chart, so you will be in good hands. You will return to your usual therapist in the next regularly scheduled visit.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. The following may seem to be a reason not to come for your treatment. A) You're feeling worse and think the treatment is not working or B) You're feeling better and it's a great day for wind surfing. Neither of these conditions is legitimate as a reason not to come in. A) If you are in pain, come in and get it fixed, B) If you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself.

To Our Patient Regarding Cancellations and No-Shows

When you don't show for a scheduled appointment, **three** people are hurt.

1. **You,** because you don't get the treatment you need as prescribed by the doctor and or the Acupuncturist.
2. **Your Acupuncturist,** who now has an open space in their schedule that was reserved for you personally.
3. **A Patient who is in pain** who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard by signing the agreement below. We're looking forward to working with you.

_____ Date_____

Patient Signature

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PATIENT HEALTH HISTORY – CONFIDENTIAL

Patient Name: _____ Today's Date: _____
Age: _____ Birth date: _____Date of last physical examination: _____
Reason for visits: _____

Symptoms Check (✓) symptoms that you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/ BONE
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Shoulders
- ☐ Neck

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting Blood

EYE/EAR/ NOSE/ THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent coughs
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-flashes
- ☐ Vision-Halos

SKIN
- ☐ Bruise easily
- ☐ Cysts
- ☐ Hives
- ☐ Itching Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Tattoo(s)

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY
- ☐ Abnormal Pap Smear
- ☐ Bleeding between period
- ☐ Breast lump
- ☐ Cysts
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?____

Are you pregnant?_____

Number of children_____

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Conditions Check (✓) symptoms that you currently have or have had in the past year.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

Medications/Supplements List any you are currently taking.

_____

_____

_____

Allergies

_____

_____

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Family History

Fill in health information about your family

Relation	Age	State of Health	Age of Death	Cause of death
Father				
Mother				
Brothers				
Sisters				

Check if your blood relatives have had any of the following:		
	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Strokes	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

Hospitalizations

Year	Hospital	Reason and Outcome

Have you ever had a blood transfusion? __Yes __No
If yes, please give approximate dates _____

Pregnancies

Year of Birth	Sex of Birth	Complications if any

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Serious Illness/ Injuries/Surgeries	Date	Outcome

Health Habits

Check which substances you use and describe how you use it.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Occupational

Check if you work exposes you to the following

	Stress
	Heavy lifting
	Hazardous Substances
	Other

Occupation_____

I certify that the above information is correct to the best of my knowledge. I will not hold my Doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date_____
Reviewed By _____ Date_____

Instructions before treatment:

- Please eat a small protein meal at least 30 minutes before arriving.
- Wear loose comfortable clothing as if you were going to the gym.
- Plan your work out BEFORE receiving acupuncture.
- Print and fill out the initial intake form online, or arrive 20 minutes early to fill out paperwork.
- Bring in any blood work, MRI, x-rays, or reports that you may have
- The first time you are getting treatment allow up to 90 mins for full evaluation and treatment.