Mulberry Oriental Medicine
910 Old Camp Rd #192
The Villages, FL 32162
352-430-2720

Health History Questionnaire

Date:_____

Name: Mr./ Mrs./ Ms._____

Address:_____

City, State, Zip:_____

Home Phone:_____ **Cell Phone:**_____

Age:_____ **Date of Birth:**_____ **Martial Status:**_____

Emergency Contact (Name and Phone Number):_____

Gender: _____ **Height:**_____ **Weight:**_____

Email: _____

Social Security Number:_____ Primary Care Doctor_____

How did you hear about our office:_____

Major Complaints, in order of signifance to you:

1. _____ 3._____

2._____ 4._____

How do these conditions impair you daily activities?_____

_____

Recent Tests: (please indicate test results and date below)

☐ Physical ☐ CT scan ☐ EMG ☐ Blood
☐ MRI ☐ X-Ray Other:_____

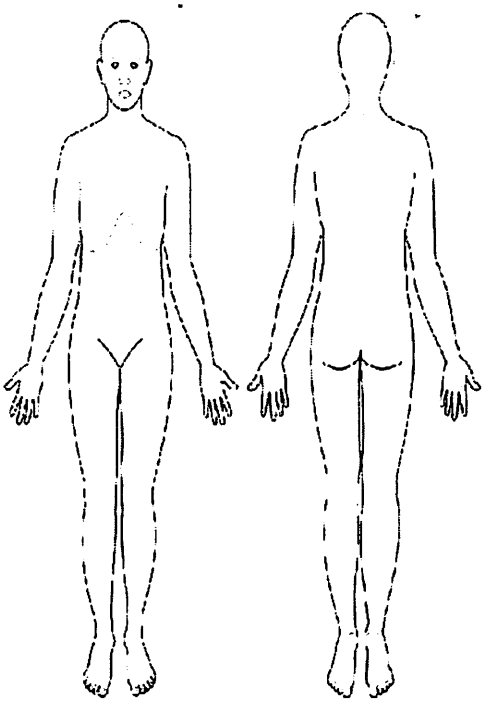
Test Results and Date:_____

Check any you have had in the past year or currently:

- ☐ Fibromyalgia
- ☐ Breathing Problems
- ☐ Migraines
- ☐ Hepatitis
- ☐ Heart Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ HIV/AIDS
- ☐ Cancer Type:_____
- ☐ Neuromuscular Disease
- ☐ Lung Disease
- ☐ Other: _____
- ☐ Digestive Disorders
- ☐ Kidney Disease
- ☐ Psychological Challenges
- ☐ Osteoporosis/ Osteopenia

Hospitalizations/surgeries:_____

Patient Profile: Mark Pain Below



Is the pain:

- ☐ Sharp
- ☐ Cramping
- ☐ Burning
- ☐ Aching
- ☐ Dull
- ☐ Moving
- ☐ Fixed
- ☐ Other_____

Do the following improve the pain?

- ☐ Pressure
- ☐ Cold
- ☐ Heat
- ☐ Exercise
- ☐ Other_____

Do the following worsen the pain?

- ☐ Pressure
- ☐ Movement
- ☐ Weather Changes
- ☐ Other:_____

How long have you had these pain symptoms?_____

Would you describe the pain as recurrent or continuous?_____

What treatments or medications are you receiving or have received for the pain?_____

Please answer the following questions based on your pain symptoms in the last two weeks.

1. How many days in the past two weeks have you been in pain?
   1-2 days 3-4 days 5-6 days 7-8 days 9-10 days 11-12 days 13-14 days

2. In the past two weeks what has your usual/average pain level been?
   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst Pain

3. On average how many hours per day has the usual/average pain lasted?
   1-2 hours 3-5hours 6-8 hours 9-12 hours 12-18 hours 18-24 hours

4. In the past two weeks what has your worst pain level been?
   0 1 2 3 4 5 6 7 8 9 10
   No pain Worst Pain

5. On average how many hours per day has the worst pain lasted?
   1-2 hours 3-5hours 6-8 hours 9-12 hours 12-18 hours 18-24 hours

Acknowledgement of Receipt of Notice of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data.
IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:
   a. Treatment – To give you medical treatment or other types of health services.
   b. Payment – To bill you or a third party for payment for services provided to you.
   c. Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object.
   a. To you.
   b. As required by federal, state or local law.
   c. If child abuse or neglect is suspected.
   d. Public health risks (for public health activities to prevent and control spread of disease).
   e. Lawsuits and disputes (in response to a court or administrative order).
   f. Coroners, medical examiners and funeral directors.
   g. Organ or tissue donation facilities, if you are an organ donor.
   h. To avert a threat to an individual or to public health safety.

III. Disclosure where we have to give you a chance to agree or object:
   a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories.
   b. Person involved in your care or payment of your care – We may share your health data with a family member, a close friend or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
   a. Right to inspect your health record and to receive a copy of your health record upon request.
   b. Right to amend information in your health record you believe is inaccurate or incomplete.
   c. Right to know to whom we have disclosed your health information.
   d. Right to ask for limits on the health information data we give out about you.
   e. Right to receive communication from us about your health information in alternate ways.
   f. Right to a paper copy of the complete Notice of Privacy Practices.

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Signature of patient or representative Date

I have read the posted HIPPA Notice of Privacy Practices posted in the waiting room and have no questions about this policy.

Print Name: _____

Signature:_____

Date:_____

Consent to Treatment

While acupuncture, Oriental Medicine and other treatment provided by this office have proven to be highly effective in correcting conditions and maintaining overall well-being, practitioners are required to advise patients that there may be some risks. Although practitioners cannot anticipate all the possible risks and complications that may arise with each individual case, you should be aware that the following side effects can occur. If there are particular risks that apply in your case, your practitioner will discuss these with you.

- Drowsiness can occur in a small number of patients, and if affected, you are advised not to drive.
- Minor bleeding or bruising can occur from acupuncture.
- In less than 3% of patients, symptoms may become worse before they improve for 1-2 days following treatment. This is usually a good sign. Please advise your acupuncturist if worsening of symptoms continues for more than 2 days.
- Fainting can rarely occur in certain patients, particularly at the first treatment.

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint, or other odd detached sensation.
- If you have a **pacemaker** or any **electrical implants**.
- If you are pregnant.
- If you have a bleeding disorder.

Statement of Consent

I confirm that I have read and understood the above information and I consent to having treatments and procedures from this office. I have read the possible risks of treatment outlined above, but do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment. I also understand that I can refute treatment at any time.

I wish to rely on my practitioner to exercise judgment during the course of treatment which, based upon the facts then known, is in my best interests. I understand that the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, 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 further conditions for which I seek treatment.

_____

Print Name

_____ _____

Signature Date

Fee Schedule and Insurance Information

If your insurance does not cover the cost of Acupuncture , the cost is as follows: ***Each Treatment: $50.00***

We offer the following discount packages. These packages are to be bought at the time of visit. Discounts are not available to those who do not sign up for a package.

4 visits:	$180.00 ($20.00 savings)	6 visits:	$240.00 ($60.00 savings)
8 visits:	$310.00 ($90.00 savings)	10 visits:	$375.00 ($125.00 savings)

Insurance notes:

1. If you are on Medicare (no coverage) and your secondary will cover acupuncture please note that in the mail you will receive a rejection letter stating that the secondary needs a Medicare EOB. We also receive that notice and take care of it in our offices. There is no need to call us if you receive that in the mail.
2. Many plans have a deductible. If your plan has a deductible and that has not been met, we will send the claim for you if there is acupuncture coverage. You will, however, be responsible for the cost.
3. If you are on a plan that is out of network, we will file for you if you have coverage.

Assignment of Benefits

I request that payment of authorized insurance benefits be made on my behalf to Mulberry Oriental Medicine for any equipment or service provided to me by Mulberry Oriental Medicine.
I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipments or services, my insurance company or other entity if requested. The original authorization will be kept on file by Mulberry Oriental Medicine.
I understand that I am financially responsible to Mulberry Oriental Medicine for any charges not covered by my health insurance company that is billed from this office. It is my responsibility to notify Mulberry Oriental Medicine of any changes in my health insurance coverage. In some cases exact insurance benefits cannot be determined by Mulberry Oriental until insurance receives the claim. I am responsible for the entire bill or balance of the bill as determined by Mulberry Oriental Medicine. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received.
By signing this document, I also acknowledge that I have received a copy of the organizations Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of Person Signing:_____

Relationship to Insured:_____

Signature of Insured:_____

Date:_____