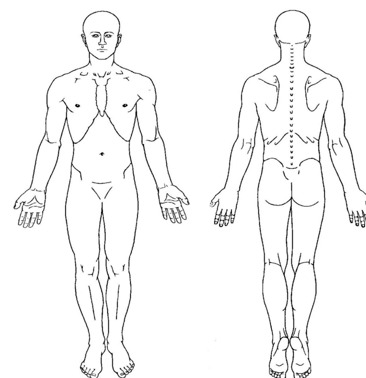
New Patient Intake Form

Name: ____Date:____________________
Date of Birth:______________ Age: _____ Email: ____
Address: ___________________________________ City, State, Zip: ____________________________
Home Phone #: ________________________ Work:__________________________
Cell:__________________________
Occupation:_______________________ Marital Status: [ ] M [ ] S [ ] W [ ] D
Height: _______ Weight: _______ Allergies:____
Emergency Contact Name: _______________________________ Phone:______________________
Relationship: __________________
PCP Name: _______________________________ PCP Phone: ______________________________

General Questions:



Have you had acupuncture before? [ ] Yes [ ] No
Chief Complaint: ____
How long have you had this condition?:____________________________
Is it getting worse? [ ] Yes [ ] No
What seemed to be the initial cause? ______________________________
What seems to make it better? ___________________________________
What seems to make it worse? ___________________________________
Are you experiencing pain right now? [ ] Yes [ ] No
Describe your pain: [ ] Dull [ ] Sharp [ ] Stabbing [ ] Shooting [ ] Burning
On a scale of 1-10 what is your pain currently? ________
What makes your pain better? [ ] Heat [ ] Pressure [ ] Movement [ ] Cold [ ] Massage [ ] Rest
Do you have a Pacemaker or any Electrical Implants? [ ] Yes [ ] No If yes, please list:

____

Are you currently on any medications? [ ] No [ ] Yes If yes, please list:

____

Please list any previous surgeries:

____

Past Medical History: *(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the follow are a significant part of your medical history)*

[ ] AIDS/HIV	[ ] Diabetes	[ ] Low Blood Pressure	[ ] Venereal Disease
[ ] Alcoholism	[ ] Epilepsy	[ ] Pacemaker	[ ] Major Trauma:
[ ] Allergies	[ ] Gout	[ ] Pneumonia	________________
[ ] Arteriosclerosis	[ ] Heart Disease	[ ] Seizures	________________
[ ] Asthma	[ ] High Blood Pressure	[ ] Stroke	[ ] Other:
[ ] Cancer	[ ] Herpes	[ ] Thyroid Disorders	________________
[ ] COPD	[ ] Hepatitis	[ ] Ulcers	________________

General Symptoms: *(Please check all that apply)*

	Nausea		Constipation
	Frequent Urination		Pain on urination
	Bleed or Bruise easily		Intestinal Pain
	Cold Hands or Feet		Poor Circulation
	Night Sweats		Sweat Easily
	Seizures		Insomnia
	Acid Regurgitation		Anxiety
	Depression		Easily Stressed
	Fatigue		Vertigo or Dizziness
	Diarrhea		Recent weight gain/loss
	Poor Memory		Fever
	Heart Palpitations		Sinus Problems
	Eczema		Facial Pain
	Difficulty Breathing		Fainting
	Asthma/Wheezing		Irregular Heartbeat
	Headaches		Migraines
	Impotence		Vomiting
	Shortness of breath		Tight Chest
	Numbness		Chest Pain
	High Blood Pressure		Dry Cough
	Low Blood Pressure		Blood Clots

Musculoskeletal: *(Please check all that apply)*

	Neck/Shoulder Pain		Upper Back Pain
	Joint Pain		Limited Range of Motion
	Muscle Pain		Low Back Pain
	Rib Pain		Muscle Spasms

I agree that the information I provided on this intake is true and it is my responsibility to inform the Acupuncturist at any point of my course of treatments if any information has changed.

Signature of Patient ______________________________________ **Date** ________________________

Self-Pay Fee Schedule

If your insurance does not cover the cost of acupuncture, the self pay fee schedule is as follows:

- **Individual Acupuncture treatment - $85.00**

We offer the following discounted treatment packages. These packages are to be bought at the time of the **first visit** and paid in full in order to receive the savings.

- **4 Visits - $300.00 ($40.00 Savings)**
- **6 Visits - $435.00 ($75.00 Savings)**
- **10 Visits - $ 650.00 ($200.00 Savings)**
- **15 Visits - $900.00 ($375.00 Savings)**
- **20 Visits - $1,100.00 ($600.00 Savings)**

Package Notes:

- Packages are nonrefundable **6 months** from the date of purchase.
- If you request a refund of your package within the six months of purchase, the used visits will convert to the individual self-pay price of $85.00 per treatment.
- Packages do not expire
- Packages are transferable

I confirm that I have read and understand the above fee schedule. By signing below, I am acknowledging and consenting the terms of the self-pay fee schedule.

Signature

____

Date

____

<u>Consent to Treatment</u>

While acupuncture, Oriental Medicine and other treatments 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 for 1-2 days following treatment before they improve. Please advise your acupuncturist if worsening of symptoms continues for more than two days.
- Although rare, fainting can 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 **<u>pacemaker</u>** or any **<u>electrical implants.</u>**
- If you are pregnant.
- If you have a bleeding disorder.

<u>Statement of Consent</u>

I confirm that I have read and understand the above information, and I consent to having treatments and procedures from this office. I have read the possible risks of treatment outlined above, and 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 refuse treatment at any time.

I wish to rely on my practitioner to exercise judgement 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 and that all 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 treatment 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 ________________________

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 your 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. Disclosure 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 our health data with a family member, a close friend or other person that you have names as being involved with your health care.

IV. Other use 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 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.

Signature of patient or representative:_______________________________ Date: ____________

Insurance Information

Mulberry Integrative Medicine verifies your insurance coverage. We contact your insurance company and speak directly with a representative who reads your policy and makes a decision on coverage based on the terms of your policy. We will only follow the results of that coverage determination. If you feel that this coverage determination is in error, please call your insurance company to verify the information and acquire a verification number. You may then give us the verification number and we will re-run your insurance with this updated information.

Insurance Notes

1. If you are on Medicare **(Must be evaluated by MD first & covers for low back pain ONLY)** and your secondary insurance will cover acupuncture, please note that you may receive a rejection letter in the mail stating that the secondary needs a Medicare EOB. We also receive that notice and take care of it in our office. There is no need to call us if you receive that notice 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 Integrative Medicine for any equipment or service provided to me by Mulberry Integrative Medicine.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services, my insurance company or other entity if requested. The original authorization will be kept on file by Mulberry Integrative Medicine.

I understand that I am financially responsible to Mulberry Integrative Medicine for any charges not covered by my health insurance company that are billed from this office. It is my responsibility to notify Mulberry Integrative Medicine of any changes in my health insurance coverage. In some cases exact insurance benefits cannot be determined by Mulberry Integrative until your insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by Mulberry Integrative 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 organization's 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: ____ Date: ___________________

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. Acupuncture **below, you may have to pay.**
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** Acupuncture below.

D.	**E. Reason Medicare May Not Pay:**	**F. Estimated Cost**
Acupuncture	Non-Covered Service	Max Per Visit $85.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** Acupuncture listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** Acupuncture listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** Acupuncture listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.** Acupuncture listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	**J. Date:**

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.