Healing Way Acupuncture

Patient Information

Name: _____ Date: _____

Date of Birth: _____/_____/ _____ Age: _____ Insurance Company: _____

Height: _____ Weight: _____ Gender: M / F Member ID Number: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Occupation: _____ Employer: _____

How did you hear about our clinic? _____

Primary Care Physician: _____ Phone Number: _____

Are there any other health care providers you are working with? If so, may we contact them? Y / N

_____

Please list all medications (prescribed & over the counter), vitamins and supplements you are currently taking:

_____

_____

_____

_____

Please list any food, drugs, or medications you are hypersensitive or allergic to AND your reaction:

_____

_____

_____

_____

Reason For Visit

Please identify the health concerns that have brought you to our clinic in order of importance below:

Condition Past Treatments

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

Do you have any reason to believe you may be pregnant? If so, how far along are you? _____

Do you have any infectious diseases? If yes, please identify: _____

Lifestyle

Do you typically eat at least three (3) meals per day? Y / N If no, how many? _____

How many glasses of water do you drink per day? _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ Do you wake rested? Y / N

Level of education completed: High School Bachelors MastersDoctorate Other

Hours/Week at work: _____ Do you enjoy work? Y / N

Why/Why Not: _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major traumas? Y / N

Explain: _____

_____

_____

Family History

Is there any significant family health history we should know about? _____

_____

Acknowledgement of Receipt of Privacy Policy

Your signature below acknowledges that you have received Notice of our Privacy Practices.

Signature: _____ Date: _____

For Insurance Patients Only

Auto / Worker's Comp Insurance

Is condition due to an accident? Y / N Auto Accident Date: _____ Work Accident Date: _____

Claim Filed? Y / N Claim # _____

Insurance Company: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above company. I assign all insurance benefits, if any, otherwise payable to me for service rendered, directly to my practitioner at Healing Way Acupuncture and Herbal Clinic. I understand that I secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient / Guardian Signature: _____ Date: _____

Financial Policy

Unless prior arrangement is made, full payment is due at the time of service. Payment may be made by cash, personal check, Visa, or MasterCard. For patients paying **in full** at the time of services, there is a 20% discount on all services. This does not apply to supplements, insurance co-pays or deductibles.

For your convenience, we will bill your insurance provider. We will contact your insurance company for verification of benefits. However, insurance companies may reimburse differently than the information they initially provide to us. You are responsible for and will be billed for any resulting unpaid balance. If we are unable to obtain a verification of benefits from your insurer for any reason, we will require full payment at the date and time of service. You are expected to pay your deductible, if it is still due, your co-payment, for any non-covered services, and for all supplements and products at the time of service.

Please provide us with notice of cancellation at least 24 hours in advance of your scheduled appointment. If cancellation notice is less than 24 hours, or you fail to come for a scheduled appointment, there will be a $50.00 fee.

Accounts greater than 30 days past due will be charged a $10.00 administrative fee. Accounts greater than 90 days overdue will be sent to a collections agency, unless you are making timely payments on an approved payment plan. If you need ongoing medical care, we expect payment on your old balance as well as payment in full for new charges at the time of service. There will be a $35.00 fee for a returned check.

Financial Agreement:

- I have read the policies above and understand them.
- I understand that I will be provided a copy of the policy at my request
- I agree to promptly pay all fees and charges for treatment provided to me and/or my family
- I understand that it is my responsibility to contact my insurance company should a claim be denied or not paid in full
- I understand that I am financially responsible for all charges, whether or not they are covered by my insurance
- I understand that if I disagree with any charges, I will contact his office in writing within 30 days of the billing date
- Should legal action be taken by this office to collect an unpaid balance due for services provided, I/we agree to pay reasonable attorney's fees or other such costs at the Court determines proper

These policies are subject to change without notice.

I have read. Understood, and agree to the policies described above:

Signature: _____ Date: _____