WISE WELLNESS

CONFIDENTIAL PATIENT INFORMATION

Please let us know who referred you!_____

Name:_____Home Phone:_____
LAST FIRST

E-Mail Address:_____ Cell Phone:_____

Address:_____ Apt:_____

City:_____ State:_____ Zip: _____ Driver's License:_____

Date of Birth: _____ Age:_____ Sex: M__ F__ T__ Place of Birth:_____

Marital Status: M__ S__ W__ D__ Spouse's Name:_____ # of Children:_____

Patient's Occupation:_____ Business Phone:_____

IN CASE OF EMERGENCY PLEASE CONTACT: _____ Phone:_____
Relationship to patient:_____

How would you like our office to contact you? Home # ___ Business # ___ Cell # ___ E-Mail ___

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CIRCLING YES

Do you have a tendency to faint?	Yes	No	Have you ever had Hepatitis?	Yes	No
Do you have a pacemaker?	Yes	No	Are you HIV positive?	Yes	No
Do you bleed for a long time?	Yes	No	Are you pregnant?	Yes	No

I DO HEREBY CERTIFY THAT THE PRECEEDING QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND COMPLETELY TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Patient/Parent/Guardian

Date

Printed Name of Patient/Parent/Guardian

Relationship to Patient

WISE WELLNESS

Office Policies

Welcome to Wise Wellness. We want you to be comfortable and to get the best care possible. Please do not hesitate to ask any questions you may have regarding your visit, billing, or our policies.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by the Office Manager. For your convenience we accept: cash, personal checks, and credit cards. **Returned checks will result in a $25 fee that will be posted to your account.** Returned checks, balances older than 30 days, and failure to pay account balances as promised may be subject to external collections and additional collection fees, including attorney and other court fees.
We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.
Cancellations: As a courtesy to our office and other patients we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $50 fee for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations.

Insurance

If you have an insurance policy that covers acupuncture, or have insurance but are unsure whether acupuncture is covered and would like to use your coverage for your visits, please provide us with the following information:

Insured's Name:_____ Insured's DOB:_____
Insured's ID #:_____ Group #:_____
Name of Insurance Company:_____ Ins.Co.Phone:_____
Insurance Company Address:_____

Patient Financial Agreement / Assignment of Benefits

I understand that services rendered to me are my financial responsibility and that the Provider will bill my insurance company as a courtesy. I authorize my insurance company to pay my benefits directly to this office and I understand that I will be fully responsible for any outstanding balance on my account.
THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.
I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service and I agree to be personally responsible for the total charges incurred by me.
I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO ADJUDICATE THIS CLAIM.
I also understand that should my insurance company send payment to me, I will forward the payment to this office with 5 days. To avoid any additional cost and inconvenience, should my insurance company forward payment to me, I authorize this office to facilitate payment utilizing the credit card information below. Charges to this card will NOT occur unless Checks from Insurance Carrier are not endorsed and received in 5 days.
THE AMOUNT CHARGED ON MY CARD WILL BE THE EXACT AMOUNT AS THE CHECK(S) RECEIVED BY MY INSURANCE CARRER.

Cardholder's Name:_____Card Type:_____
Cardholder's Address:_____
Account #:_____ Exp:_____Security Code:_____
Cardholder Signature:_____Date:_____

By signing below, I agree to comply with the office policies stated above which I have read and understood. I also authorize the use of this signature on all insurance submissions.

Patient Signature:_____ Date:_____

WISE WELLNESS

PATIENT INFORMED CONSENT

I hereby request and consent to the performance of acupuncture and other Chinese medicine procedures by the licensed acupuncturist **Yaron Cohen** and/or other licensed acupuncturists who now or in the future treat me while working with Mr. Cohen, or serves as a back-up for Mr. Cohen in the event of a necessary cancellation, including those working in the same office, whether signatories to this form or not.

I understand that the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, tui na, gua sha, electrical stimulation, infrared heat, herbs, therapeutic exercises, and dietary and lifestyle counseling. I have been informed of the potential risks associated with these treatment modalities.

I understand that the herbs need to be consumed according to the instructions provided orally and in writing. I understand that some herbs may have an unpleasant taste or smell. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant.

I do not expect the acupuncturist to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this 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.

_____	Yaron Cohen, L.Ac., Dipl.OM.
Print Name of Patient	Print Name of Acupuncturist
X_____	X_____
Signature of Patient or Representative	Signature of Acupuncturist
_____	_____
Print Name of Patient Representative	Print Name of Witness or Translator
_____	X_____
Date Consent Completed	Signature of Witness or Translator

Notice of Privacy Practices
Patient Acknowledgment

Patient Name: _____ Date of Birth: _____

I have received the practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practices legal duties with respect to my protected health information. The notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and healthcare operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses or disclosures that will be made only with my written authorization and that may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complaint to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restriction on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice current notice of privacy practices upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

WISE WELLNESS

TREATMENT INFORMATION

Chief Complaint(s) *Please indicate how long you've had the condition(s).*

Other Complaint(s) *Please indicate how long you've had the condition(s).*

What kinds of treatments have you received? *Please indicate dates and duration of treatment.*

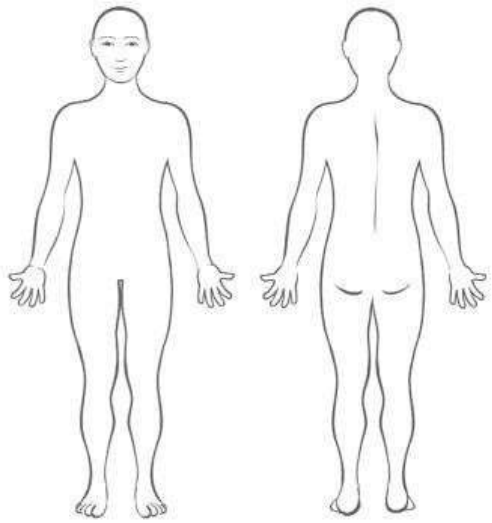
List any Hospitalizations & Surgeries / Childhood Illnesses **Date**

_____
_____
_____
_____

List medications (pharmaceuticals / supplements) being taken (include dose)

_____
_____
_____
_____

Please mark any areas of pain or discomfort:



Intensity (1-10):_____

Frequency:_____

Duration:_____

Nature:_____

Comments:_____
_____
_____
_____
_____
_____

WISE WELLNESS

REVIEW OF SYSTEMS

Gastrointestinal

- ☐ Low appetite
- ☐ Weight change
- ☐ Nausea
- ☐ Vomiting
- ☐ Excessive hunger or cravings
- ☐ Abdominal distension / Gas
- ☐ Indigestion / Reflux / Heartburn
- ☐ Thirst

Bowel Movement: (circle all that apply)

Undigested Food / Watery / Unformed / Formed Soft / Normal / Hard / Dry / Large / Little Pellets

Frequency: Less than 1x a day / 1-2x a day / 2+ times a day

Color: Brown / Light Brown / Black / Green / Red (blood) / Yellow

Respiratory

- ☐ Cough (chronic / acute)
- ☐ Phlegm / Mucus / Congestion
- ☐ Allergies
- ☐ Asthma / Difficulty breathing
- ☐ Skin issues or Rashes
- ☐ Low Immunity / Frequently ill

Genitourinary

- ☐ Incontinence
- ☐ Nighttime urination
- ☐ Libido: low / normal / high
- ☐ Dental issues
- ☐ Urinary frequency
- ☐ Painful urination
- ☐ Sexual dysfunction / Infertility
- ☐ Prostate problems

Neurological

- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Poor coordination
- ☐ Hearing loss / Tinnitus
- ☐ Seizures / Spasms
- ☐ Dizziness / Vertigo
- ☐ Weakness
- ☐ Eye / Vision dysfunction

Cardiovascular

- ☐ Palpitations
- ☐ Arrhythmia
- ☐ Edema
- ☐ Hypertension
- ☐ Low blood pressure
- ☐ Hot/Cold Hands/Feet

Psychiatric

- ☐ Anxiety
- ☐ Mania
- ☐ Poor memory
- ☐ Drug / alcohol abuse
- ☐ Depression
- ☐ Anger / irritability
- ☐ Brain fog
- ☐ Suicidal thoughts

Sleep:

- ☐ Difficulty falling asleep
- ☐ Difficulty getting back to sleep
- ☐ Night sweats
- ☐ Difficulty staying asleep
- ☐ Difficulty waking
- ☐ Vivid dreams / Nightmares

Bed Time:_____

Avg. # of hours:_____

Wake Time:_____

Restful? Yes / No

Systemic

Energy level (1-10):_____

- ☐ Tend to run hot / Prefer cold
- ☐ Fever / Chills

Stress level (1-10):_____

- ☐ Tend to run cold / Prefer warmth
- ☐ Sweating

WISE WELLNESS

For Women

_____ Number of pregnancies
_____ Number of miscarriages
_____ Number of abortions
_____ Number of births

_____ Age of 1st menstruation
_____ Date of last menstruation
_____ Cycle length (day 1 to day 1)
_____ Duration of menstruation (days of flow)

Please check all that apply to your menstruation:

- ☐ Irregular periods
- ☐ Painful periods / cramps
- ☐ Clots
- ☐ Heavy flow
- ☐ Thick consistency of flow
- ☐ Moodiness
- ☐ Breast tenderness
- ☐ Digestive disturbance / cravings
- ☐ Light flow
- ☐ Thin / watery consistency of flow

Color of menses: Red / Bright Red / Dark Red / Pale Red / Purple / Brown

Please check if you have had any of the following:

- ☐ Breast lumps
- ☐ Endometriosis
- ☐ Uterine fibroids
- ☐ Hot flashes / night sweats
- ☐ Vaginal sores
- ☐ Vaginal discharge
- ☐ Ovarian cysts
- ☐ Osteoporosis

Are you allergic to any of the following? (If yes, please specify)

- ☐ Medications _____
- ☐ Food s _____
- ☐ Herbs _____
- ☐ Other _____

Family History (Please include relation)

- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Epilepsy _____
- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Mental Illness _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____

Lifestyle

Please describe any physical activity or exercise regimen you like to practice along with frequency:

_____
_____
_____
_____

Diet

Please give an example of your typical dietary routine:

_____
_____
_____
_____

	No	Yes	When Started	When Stopped	Amount (per week)
Coffee	___	___	_____	_____	_____
Alcohol	___	___	_____	_____	_____
Tobacco	___	___	_____	_____	_____
Other	___	___	_____	_____	_____