Patient Information

Name_____ Date _____

Address_____ Zip _____

Cell No. _____ Home No. _____

DOB _____ Email _____

Referred by _____

Emergency Contact Name _____

Emergency Contact No. _____ Relation _____

PCP Name_____ PCP No._____

Main complaint _____

Secondary complaint _____

When did this start? _____

Have you previously seen a doctor for this problem(s) _____

Pain/Complaint: Scale of 1-10 (10 is worst) _____

What makes it better? _____

What makes it worse? _____

Please list any medications/herbs currently being taken & why

_____

_____

_____

Please list any surgeries/operations you have previously had

_____

_____

_____

PLEASE READ AND SIGN

I consent to acupuncture treatments and other procedures associated with the practice of traditional Oriental medicine provided by Dynamic Wellness Inc. I have discussed the nature and purpose of my treatment with the member of the clinical staff named above.

I understand that methods of treatments may include but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, AMMA Therapy, and Tui Na . I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness, or tingling near the needling sites that may last a few days, and dizziness or fainting. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture(pneumothorax). Infection is another possible risk, although the site uses sterile, disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other effects and risks may occur.

I will notify the clinical staff member who is caring for me if I am 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 judgement during the course of treatment which the clinical staff thinks at the time, based on the facts known to them, is in my best interests.

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 risk and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I have read this form and freely give permission to receive acupuncture.

Date_____

Signature of Patient or Representative_____

Print name of Patient or Representative_____

Dynamic Wellness

This office is HIPPA compliant. This and all patient information is kept strictly confidential.
Your written request is required to authorize release to any other party.

Insurance Verification Form

If insured information is different from patient information please complete the following:

Name of insured _____ Sex _____

Address of insured _____

City _____ State _____ Zip _____

Contact phone_____ Insured DOB _____

Relationship to patient _____

Insured's Employer _____

Address_____

Primary Insurance

Name _____

ID# _____

Group# _____

Address _____

_____

Provider # _____

Secondary Insurance

Name_____

ID#_____

Group# _____

Address _____

_____

Provider# _____

I request that payment of authorized medical benefits be assigned on my behalf to Dynamic Wellness Inc./Andrea Conte LAc, for services furnished to me by her or under her supervision. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits payable for related services. To avoid misunderstandings regarding acupuncture and insurance we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees unless other arrangements are made in advance. We will prepare necessary forms to obtain your benefits from insurance companies. We do not render our services on the basis that insurance companies will pay for all of our fees. Should your account be tendered to a collection agency for non-payment, regardless of reason, you will be assessed and charged the exact collection fee charged to us to collect your account.

I have read the above statement and fully understand its meaning and signify by my signature below.

Signature _____ Date _____

Assignment of Benefits (AOB)

I_____(Patient Name) hereby certify that I am eligible for_____(Insurance Name) as of_____(Effective Date). I understand that if I am not eligible I will be financially responsible for all services rendered and I agree to pay in full for said services within 30 days of receiving a bill.

In addition, I _____(Patient Name), hereby guarantee when I receive checks and EOB's from my insurance company I will give them to your office, Andrea Sierra Dynamic Wellness Inc.

I, _____(Patient Name), hereby assign and direct to pay any and all benefits for medical services to the office of Andrea Sierra, Dynamic Wellness Inc.

I, _____(Patient Name), hereby authorize release of any medical information requested by the insurance company in order to facilitate payment of said claims.

Patient Signature _____

Date _____

Privacy Statement And Patient Authorization For Disclosure Of Personal Health Information

Dynamic Wellness Inc. has informed me by this document that certain policies are in effect in their office, to insure my right to confidentiality of my personal health information. The doctor has informed me that this letter will cover the elements required in the HIPPA (Health Information Privacy Protection Act of 1996) regulations that go into effect April 14, 2003. My signature below signifies that I may have received this document and understand the intent and content of it. That it protect my rights to privacy, my ability to inspect and change any part of the chart. The addendum is to be completed in the presence of the doctor or of the designated office personnel.

The doctors are providers of record and are responsible for maintaining my health record and confidentiality at all times. Their office staff, including administrative and ancillary medical attendants have been counseled and trained in regards to the confidentiality of my medical record and will not discuss my care, nor have access to confidential information that is not required for them to perform their duties. Their duties require filing of reports within the chart, maintaining records, securing records, communication with insurance companies and governmental agencies. They are to be discreet and avoid incidental disclosure as best as physically possible within the confines of the office.

My signature below further authorizes the doctors and their staff to release pertinent health information for routine purposes such as treatment, communication with consultants, and other health care providers necessary to adequately provide for my complete health care, and payment by third party payers. This applies to all forms of communication, either paper or electronic. “Minimal Disclosure” of information will be permitted sufficient to comply with results from employers and to process workmens compensation claims. Government agencies including health department may be notified in reporting disease conditions required by state law.

On proper signing of an authorization to release information, I consent to have the doctor release to me or any individual agency I designate, or to my next of kin, if I am mentally or physically incapacitated to give my permission, a copy of my medical record in part or whole. I acknowledge that there will be a charge for such copying of the chart as prescribed by law and that copy will be available within 10 working days.

I have had the opportunity to ask questions. I acknowledge that at any time I may change any and all restrictions herein about sharing my health information. I give the doctors and their staff permission to utilize my protected information as described above in order to conduct their business and provide for my necessary medical care. This document shall remain in effect unless I direct otherwise.

Patient Name_____

Signature_____

Date_____

Dynamic Wellness

Patient Advisory To Consult A Physician

Dynamic Wellness Inc. is committed to your health and well-being. We believe that while Oriental Medicine has a great deal to offer as a health care system, it can't totally replace the resources available through biomedical physicians. Consequently, we recommend that you consult a physician regarding any condition or conditions for which you are seeking acupuncture treatment.

To comply with Article 160. Section 821 I.I(b) of NYS Education law, we request that you read and sign the following statement.

WE THE UNDERSIGNED, DO AFFIRM THAT_____(Patient) HAS BEEN ADVISED BY DYNAMIC WELLNESS INC. STAFF (LICENSED ACUPUNCTURIST) TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH A PATIENT SEEKS ACUPUNCTURE TREATMENT.

Patient Name (Printed) _____

Patient Signature _____

Date _____