Dao Healing Center

Confidential Health History

name_____date_____

street
address_____telephone_____

city_____zip code_____date of birth_____

email_____marital status_____

number of children(ages)_____

nearest relative and phone#_____

employment_____

health
carrier_____

hobbies or special interests_____

philosophical or religious affiliation (optional)_____

referred by_____

primary physician_____

list any medications or supplements_____

_____

have you had acupuncture before_____

primary complaint (describe your symptoms and condition)_____

_____

_____

_____

_____

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Confidential Health History

onset of current condition_____

what do you think may have caused this condition_____

_____

has anything helped condition_____

does anything make worse_____

health history (include accidents, injuries, surgeries, allergies, etc..)_____

_____

_____

_____

_____

do you have high blood pressure or any heart problems_____

parents health_____

what season do you prefer_____

what climate do you prefer_____

how is your energy level_____

how is your appetite_____

how is your digestion_____

how much fluid do you drink daily_____

do you have regular daily bowel movements_____

is stool consistently (check) ☐ loose ☐ hard ☐ light-colored ☐ dark ☐ watery ☐ mucus ☐ blood

do you urinate less than 4 times daily or more than 6 times_____

nighttime urination_____

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do you follow any special diet (ie weight loss, raw, organic, etc)_____

_____

check any of the following that you use daily:

☐ alcohol ☐ coffee ☐ diet sodas ☐ sugar ☐ marijuana ☐ cocaine ☐ recreational drugs

do you exercise regularly_____

are you sensitive to heat or cold_____

how is your sleep_____

how is your memory_____

FOR WOMEN:

do you have any menstrual problems_____

are periods regular_____length of cycle_____

do you experience pain_____is your flow: ☐ heavy ☐ light ☐ moderate

which best describes menstrual blood: ☐ normal, ☐ pale, ☐ bright red, ☐ dark, ☐ many clots

number of pregnancies_____births_____

miscarriages_____abortions_____

are you taking birth control (how long)_____

how would rate your libido: ☐ high ☐ normal ☐ low

FOR MEN:

do you have any urination problems: ☐ dribbling, ☐ incomplete flow, ☐ urgency

_____

how would you rate your libido: ☐ high ☐ normal ☐ low

do you experience erection difficulties_____

List Other Practitioners:

i.e. Family MD, Gynecologist, Chiropractor, Nutritionist, Therapist, etc.

Name Phone

_____

_____

_____

_____

_____

Emergency Contact:

_____

name phone relationship

Payment Policy

- **Full Payment Is Due At The Time Of Treatment**. Cash and checks are acceptable methods of payment. Alternative payment methods may be made if agreed upon by the parties before treatment is provided.
- Direct bill for insurance payment is an acceptable payment method; however, it is your responsibility to contact your insurance carrier to determine coverage for acupuncture treatment, co-payment required, and policy limits. **If your policy requires a co-pay, this payment is due at the time of treatment**.
- If your yearly policy limit have been reached for covered acupuncture treatment, you will be responsible for all incurred treatment fees after this point, until your benefit period renews.
- Appointment cancellations must be made **at least 24 hours** in advance. **A $75 fee will be assessed for missed appointments**.

Notice of Privacy Policy

This clinic is dedicated to providing service with respect for human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. *This notice will remain in effect until it is replaced or amended by changes in law.*

Information that we receive from you, other healthcare providers and/or third party payers is used for your treatment, payment of your bill and our healthcare operations. You may specifically authorize us to use protected health information or to disclose your health information by submitting the authorization in writing to us.

We may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation, and/or your employer if required, or with other medical practitioners that you authorize. This clinic will not use your health information for marketing purposes without your written authorization. We may, however, send you birthday cards, newsletters and appointment reminders, by telephone or mail.

Disclosure
When required by law, this office may use or disclose your protected health information.

Patient Rights
1. Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee (minimum of $15 or legal amount) and 10 working days for us to process this request.
2. Upon written request, you have the right to receive a list of items this office disclosed about your healthcare information.
3. You have the right to request that this office place additional restrictions on disclosure of your protected health information.
4. You have the right to request in writing that we amend your protected health information.
5. You have a right to receive all notices in writing.

If you have questions, complaints or want more information, please contact this office. You may send written complaints to the U.S. Department of Health and Human Services.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received, read, reviewed, understand my rights and agree to the statement of the Privacy Policy for healthcare services in this clinic. By way of my signature below, I provide *Dao Healing Center* with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Privacy Notice.

Patient Signature: _____ Date:_____