Confidential Client Information

Blue Heron Wellness
10723B Columbia Pike
Silver Spring, Maryland 20901

Phone: 301-754-3730
Fax: 301-754-3731
info@blueheronwellness.com

Please Print Clearly

Name:_____Date:_____

Home Phone:(_____)_____Mobile:(_____)_____

Work:(_____)_____ext:_____

Address:_____Apt:_____

City:_____State:_____Zip:_____

Email: _____Date of Birth:(mm/dd/yyyy)_____

Gender:(circle one)____M_____F_____

Referred by:_____

Emergency Contact Name:_____Relationship:_____

Phone Number:(_____)_____Email:_____

Your Occupation:_____

Do you have any reason to believe that you might be pregnant?_____Y_____N_____

If so, how far along are you?_____

Please list any medications (prescribed or over the counter), vitamins, herbs or supplements you are currently taking and the reasons for taking them:_____
_____
_____
_____
_____
_____

Please list any foods, medications or environmental substances you are hypersensitive/allergic to and what is your reaction:_____
_____
_____
_____

Acupuncture Health History Questionnaire

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Please Print Clearly, Please Fill Out All Pages

Name:_____Date of Birth:(mm/dd/yyyy)_____

When and where did you last receive health care?_____

For what reason? _____

Please identify the health concerns that have brought you here in order of importance below:

Condition **Past Treatment**
a. _____ _____

How does this condition affect you? _____

Condition **Past Treatment**
b. _____ _____

How does this condition affect you? _____

Condition **Past Treatment**
c. _____ _____

How does this condition affect you? _____

Condition **Past Treatment**
d. _____ _____

How does this condition affect you? _____

Do you have any infectious diseases? Y N

If yes, please identify: _____

Family History:	Self	Father	Mother	Brothers	Sisters
Check those applicable: How many:	xxxxxxxx	xxxxxxxx	xxxxxxxx	_____	_____
Age (if living):	_____	_____	_____	_____	_____
Health (Good/Poor):	_____	_____	_____	_____	_____
Cancer:	_____	_____	_____	_____	_____
Diabetes:	_____	_____	_____	_____	_____
Heart Disease:	_____	_____	_____	_____	_____
High Blood Pressure:	_____	_____	_____	_____	_____
Stroke:	_____	_____	_____	_____	_____
Mental Illness:	_____	_____	_____	_____	_____
Asthma/Allergies:	_____	_____	_____	_____	_____
Kidney Disease:	_____	_____	_____	_____	_____
Age at Death:	xxxxxxxx	_____	_____	_____	_____
Cause of Death:	xxxxxxxx	_____	_____	_____	_____

Blood Pressure: What is your most recent reading: _____/_____ When was this reading? _____

Your height: _____Your current weight:_____

Childhood Illnesses: (please circle any you may have had) Scarlet Fever Rheumatic Fever

Diphtheria Mumps Measles Chickenpox German Measles Polio

Other : _____

Immunizations: (please circle any you may have had) Polio Tetanus Pertusis

Diphtheria Hib Hepatitis B MMR

Other: _____

Hospitalizations and Surgeries :

Reason:_____ When:_____

Reason:_____ When:_____

Reason:_____ When:_____

In this section please *circle* any symptoms/conditions you experience now and *underline* any you have experienced in the past:

Emotional:

Mood Swings Nervousness Mental Tension Depression AnxietyStress

Energy and Immunity:

Fatigue Slow Wound Healing Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose and Throat:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Headaches Sinus Problems Nose Bleeds

Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory:

Pneumonia Frequent Colds Difficulty Breathing Persistent Cough

Shortness of Breath Other Respiratory Problems: _____

Cardiovascular:

Heart Disease Chest Pain Swelling of Hands or Feet High Blood Pressure

Palpitations/ Flutter Stroke Heart Murmurs Varicose Veins Rheumatic Fever

Other Cardiovascular Problems: _____

Gastrointestinal:

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Excess Gas

Heartburn Gallbladder Disease Liver Disease Hepatitis Hemorrhoids

Abdominal Pain Bloating Constipation Diarrhea Rectal Bleeding

Genito-Urinary:

Kidney Stones Kidney Disease Painful Urination Frequent Urination

Blood in Urine Frequent Urinary Infections Frequent Urination at Night

Menstrual/ Birthing History:

Irregular Cycle Breast Lumps/Tenderness Heavy Periods Vaginal Discharge

Menopausal Symptoms Premenstrual Problems Bleeding between Cycles Clotting

Painful Periods Infertility When was your last Pap Smear? _____Results:_____

Female Reproductive:

Age of First Menses:_____# Days of Menses:_____

Length of Cycle:_____ Birth Control Type:_____

# of Pregnancies: _____# of Miscarriages: _____ # of Live Births: _____ # of Abortions: _____

Male Reproductive:

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal:

Neck/ Shoulder Pain Upper Extremity Pain Lower Extremity Pain Muscle Weakness

Back Pain: Upper Mid Lower Joint Pain: Where: _____

Neurologic:

Vertigo/Dizziness Paralysis Numbness/ Tingling Loss of Balance Seizures

Endocrine:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Night Sweats Feeling Hot/Cold

Other:

Anemia Cancer Eczema/Hives/Other skin conditions Cold Hands/ Feet Lymphatic System

Is there anything else we should know? _____

_____

Lifestyle:

Do you typically eat at least three meals a day? Y N If no, how many? _____

Do you exercise? Y N If yes, how long/ how many days per week? _____ /_____

How many hours per night do you sleep? _____ Do you wake up during the night? Y N

Do you go back to sleep w/o problem? Y N Do you wake up rested? Y N

Occupation? _____

How many hours per week do you work? _____

Do you enjoy work? Y N Why/ Why not? _____

Nicotine/Alcohol/Caffeine Use: _____

Have you experienced any major trauma? Y N Explain: _____
_____

How many glasses of non-caffeinated, non-carbonated beverages do you drink a day? _____

Interests/Hobbies_____
_____

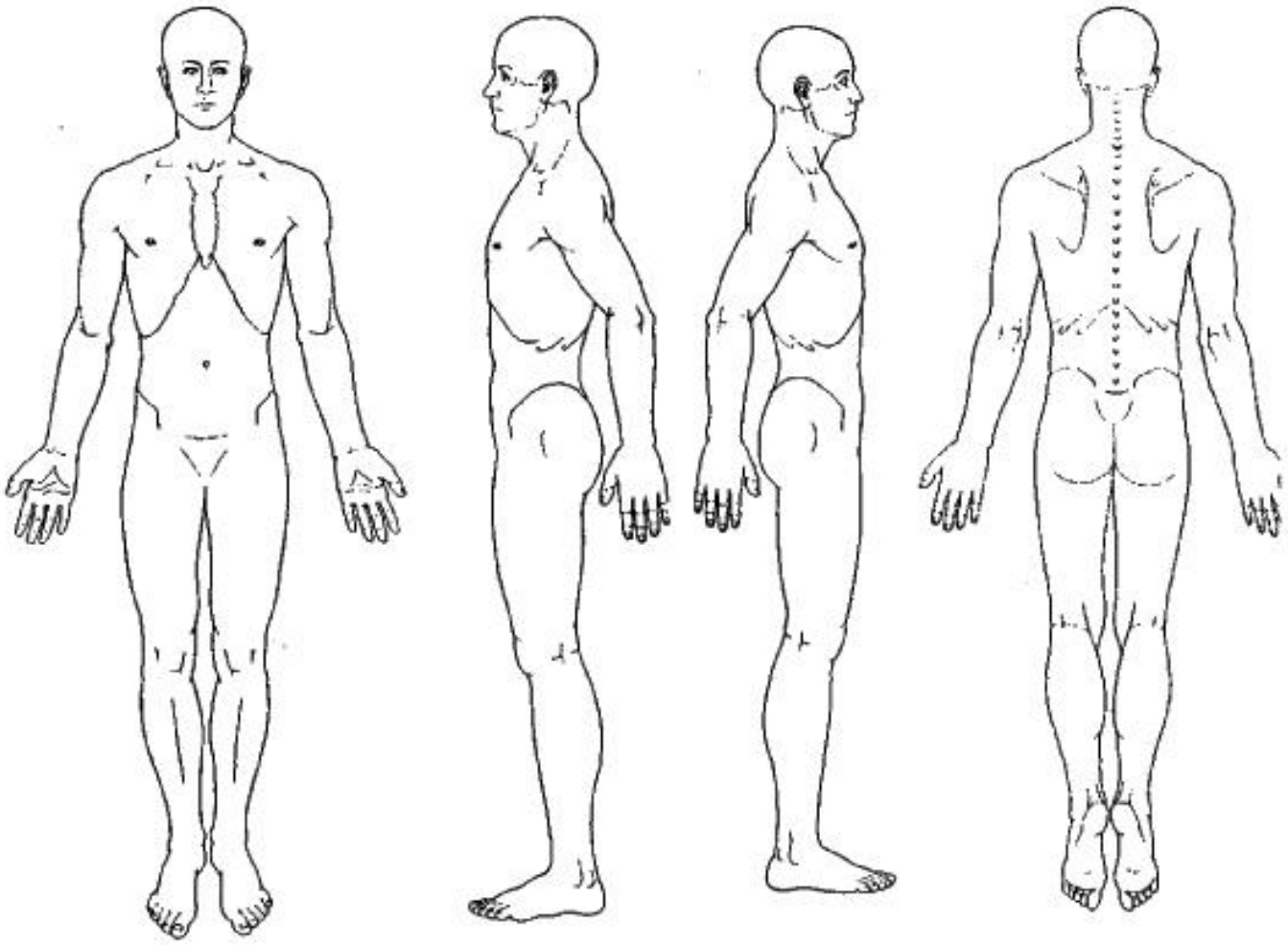
The Health History & Exam Systems have been reviewed in person with the patient by:

Examining Acupuncturist;_____

Date:

_____

Pain Location Diagram



Mark on Figures the Areas of Pain or Discomfort

Pain & Tenderness = O
Numbness & Tingling = ZZ
Swelling & Stiffness = X

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Acupuncture Insurance Verification Form

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Please print clearly and complete all sections, front & back. Please provide insurance card to front desk so that we may make a copy.

PATIENT INFORMATION

Patient Name:_____Date:_____

Phone:(_____)_____

Address:_____Apt:_____

City:_____State:_____Zip:_____

Date of Birth:(mm/dd/yyyy)_____Gender:(circle one)___M_____F_____

Your Insurance ID#:_____

POLICYHOLDER INFORMATION

CHECK HERE FOR "SELF" _____

Name:_____

Phone:(_____)_____

Address:_____Apt:_____

City:_____State:_____Zip:_____

Relationship to Client:(circle one)___Self_____Spouse_____Parent/Guardian_____

Do you have a Referral from your Primary Care Physician?(circle one)___Yes_____No_____
(If so, please provide referral paperwork to front desk staff)

Policyholder Insurance ID#:_____

Provider Services Phone:(_____)_____

Please complete reverse side of this form.

Blue Heron Wellness
Statement of Patient Financial Responsibility

Patient Name:_____ DOB: _____

Insurance Coverage for Acupuncture Treatment

As a courtesy to our clients, Blue Heron Wellness has agreed to accept payment from insurance companies on your behalf. We understand that this will make acupuncture treatment more affordable for you. We agree to bill for services and to collect payment from certain insurers on your behalf. Please recognize that you are ultimately responsible for payment of your bill.

Insurance Billing and Payments

You agree to allow Blue Heron Wellness to bill your insurer on your behalf. Further, you authorize your insurer to pay any benefits for Acupuncture treatments directly to Blue Heron Wellness. As you are ultimately responsible for payment of services, you also agree to provide to and maintain a valid credit card for Blue Heron Wellness during this time.

Payments Due from You

Your insurance carrier will cover the costs of your treatment your insurance coverage permits. Usually there are copayments, coinsurance, and deductibles that you may be required to pay. These amounts will be outlined in the ***"Explanation of Benefits"*** provided by your carrier. We require that you provide a valid credit card. We will charge only those amounts defined by your carrier as ***"Patient Responsible"*** amounts and we will send a receipt after we have processed the payment.

Type of Card: (Please circle) VISA MASTERCARD AMERICAN EXPRESS

Account Number:_____ Expiration Date: _____

Security Code (3 or 4 digit # on back or front of card): _____ Name on Card: _____

Billing Address: _____

_____

I prefer to pay by check. (Please sign)_____

By signing this Statement below, you acknowledge that you have read the above policy regarding your financial responsibility to Blue Heron Wellness for providing Acupuncture services to you or the above named patient. You certify that the information is, to the best of your knowledge, true and accurate.

Patient Signature _____ Date _____

Guarantor Signature _____Date _____
(If guarantor is not the patient)

Patient/Guarantor Signature _____ Date _____

Before and After Your Acupuncture Treatment

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To assist you in deriving the greatest benefit possible from your acupuncture treatments, please observe the following:

1. Do not wear make-up, perfume or heavily scented lotions, shampoos or soap to treatment. This is particularly important your first couple of treatments.

2. Avoid alcohol for 24 hours before and after treatment.

3. It is important to have something in your stomach prior to treatment. However it is best not to eat an unusually large meal either before or immediately after your treatment.

4. Avoid very hot or cold baths or showers the day of treatment.

5. Do not rush to your appointment! It is better to be a few minutes late than to arrive with an elevated pulse or blood pressure.

6. Continue all prescription medications and treatments exactly as directed by your physician or other health care providers.

7. Plan your activities so that after treatment (especially at first) you can get some rest and allow your body to gain the maximum benefit from treatment.

8. Note and report any changes in physical or emotional patterns that occur between your acupuncture treatments.
These details are valuable in planning the course of your treatment.

9. Avoid strenuous workouts the day of treatment.

Please keep this sheet for future reference.

Voluntary Consent

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I hereby voluntarily request and consent to be treated or give permission for my child/ward to be treated, with acupuncture, moxabustion, herbs, Asian Bodywork or other supplemental recommendations, administered by a licensed acupuncturist at **Blue Heron Wellness**. The procedures involved in these treatments have been fully explained to me. I understand that I may be treated with the insertion of needles, touch/palpation, and/or the application of heat to the skin. I have not been guaranteed any success concerning the uses and effects of these treatments. I understand that I am free to discontinue treatment at any time.

Possible Side Effects/Healing Reactions
I understand that acupuncture and moxabustion may result in certain side effects, including local bruising, slight bleeding, fainting, temporary pain or discomfort, mild burning and blistering, and temporary aggravation of symptoms existing prior to treatment. Conventional medical therapy may also be indicated, either in response to an emergency or as deemed necessary at the discretion of a licensed physician.

Medical Referral
I understand that I should consult a licensed physician for appropriate medical evaluation and treatment of the conditions for which I am seeking acupuncture treatment. Treatment from this practitioner does not substitute for appropriate medical treatment by a licensed physician.

I have been advised that if there is a worsening of my ailment or condition, or if it does not improve within the time estimated by the acupuncturist at the beginning of treatment, or if a new ailment or condition arises, I should again consult a licensed physician.

If I am presently under the medical care of a physician, I have been advised to continue all medications and treatments as prescribed until such time as my physician deems it appropriate to reduce or discontinue the medications or treatments.

Infectious Disease/Clean Needle Procedures
I understand that there is infectious disease carried through the air, through physical contact, and through body fluids. I understand that universally prescribed precautions will be utilized to guard against the spread of infection, including the use of sterilized prepackaged, disposable needles. Needles that are used for my treatment are used only on me, and are inserted according to clean procedures based on nationally prescribed standards.

I understand that my questions about the safety of any procedure or treatment or the precautions taken by the practitioner are most welcome and will be answered as fully as possible. I understand I have the right to refuse any treatment or procedure.

Fees
I understand and agree that I am responsible for payment of all fees associated with treatment. If I am using health insurance or another third-party payment option, I understand that I am responsible for all fees not covered.

Cancellations & Confirmation Calls
I understand that my appointment is reserved for me and I agree to pay the full fee for the missed session if I cancel an appointment with less than 24 hours notice (other than for serious illness or accident) I will leave my VISA, Master Card or American Express card number (stored confidentially) with the front desk so that my card can be charged for a missed appointment.

I give Blue Heron Wellness permission to contact me via telephone and/or e-mail to confirm my scheduled appointments.
☐ Yes ☐ No

I have read this form carefully and understand the entire contents. I have felt free to ask any questions.

_____ _____
Printed Name of Client Signature of Client

_____ _____
Printed Name of Guardian (if applicable) Signature of Guardian (if applicable)

_____ _____
Signature of Witness Date

Notice of Privacy Practices

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This notice, and the accompanying Practices Regarding Disclosure of Patient Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. The Notices are posted in the waiting room and copies are given to all individuals receiving care. Please review this information carefully.

Understanding your health record: A record is made each time you visit **Blue Heron Wellness**. Your symptoms, the practitioner's judgments, and a plan of treatment are recorded. This record serves as a basis for planning your care and treatment at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights: Your health record is the physical property of **Blue Heron Wellness**, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions on certain uses and disclosures of your information, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information. Should we need to contact you, you have the right to request communication by alternate means or to alternate locations.

Our responsibilities: **Blue Heron Wellness** is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Blue Heron Wellness reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, **Blue Heron Wellness** agrees not to use or disclose your health information without your authorization.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact **Blue Heron Wellness**. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

A copy of our Standards and Practices regarding Privacy of Patient Records will be provided to you upon written request.

I, _____, have received a copy of this Notice of Privacy Practices and the accompanying Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these Notices.

Client/Patient Signature:_____Date:_____

Signature of Witness:_____Date:_____

Blue Heron Wellness
Practices Regarding Disclosure of Patient Health Information

Your health information will be routinely used for treatment, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

- **Treatment** – Information obtained by your practitioner at **Blue Heron Wellness** will be entered in your record and used to plan the course of treatment. Your health information may be shared with others involved in your care or providing consultation about your treatment. Your practitioner's own expectations and those of others involved in your care may also be recorded.
- **Payment** – Your record will be used to receive payment for services rendered by **Blue Heron Wellness**. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions, and procedures performed.
- **Quality Monitoring –** The staff in this office will use your health information to assess the care you received and compare your treatment outcome to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and Drug Administration (FDA) –** This office may be required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation –** This office will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health –** This office may be required by law to disclose health information to public health and/or legal authorities charged with tracking reports of birth and morbidity. This office may be further required by law to report communicable disease, injury, or disability.
- **Law Enforcement –** (1) Your health information will be disclosed in response to a valid subpoena for law enforcement purposes, as required under state or federal law. (2) In the event that a staff member or business associate of this office believes in good faith that one or more patients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards, provisions of federal law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys.

It is the office's practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, the office will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Business Associates –** Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.
- **Communications with You and Your Family –** Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts. **Blue Heron Wellness** reserves the right to contact you with appointment confirmation or reminders, or other information about treatment. Using our best judgment, we may leave messages on telephone answering systems or send electronic mail messages. If you wish us to use any particular discretion in contacting you, please notify us in writing. **Blue Heron Wellness** may add your name to a mailing list of patients in order to send you a newsletter of information about treatment alternatives, services, seminars, and other health-related benefits that you may find useful.