New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

New York Sports Acupuncture

Patient Name **Date**

General Information

Address City State

Home Phone Occupation Zip

Work Phone Mobile Phone SS# Date of Birth

Email Address

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact Relationship Phone

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician Phone

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for?

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for?

Insurance Information

Insurance Company Phone Date Called

ID # Co-Pay $ Covered %

Visit # Deductible Amount

Contact Name Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office?

What was the initial cause?

When did it begin?

What makes it worse?

What makes it better?

How does this problem interfere with your daily activities?

☐ Work ☐ Standing ☐ Sexually ☐ Other
☐ Sleep ☐ Emotional ☐ Recreation
☐ Walking ☐ Relationships ☐ Bending
☐ Sitting ☐ Social Life ☐ Stretching

What have you done about this?

Are you interested in:

☐ Pain Relief ☐ Holistic Health ☐ Stress Relief ☐ Other
☐ Preventative Care ☐ Stretching/Yoga ☐ Herbal Therapy
☐ Oriental Nutrition ☐ Maintenance Care

What are your health goals?

List any past or future surgeries:

List any significant trauma & when it occurred
(e.g. auto accident, falls, emotional, sexual, etc.):

List exercise and sport activities you
have been or are currently involved in:

Disclosure of the Risks and Benefits of Acupuncture Care

I consent to acupuncture treatment and other procedures associated with Traditional Oriental Medicine. I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation, and Tui Na therapeutic Chinese Massage.

Acupuncture practitioners are trained in strict standards for clean needle technique and must abide by the standards set by Occupational Safety and Health Administration regarding proper hygiene and sterilization of equipment, disposal of hazardous materials, as well as precautions regarding blood borne pathogens and clean needle technique. With disposable needles, there is no risk of AIDS from the needles or hepatitis.

The risk of side effects could include some pain in the treatment area, minor bruising, moxa burn or scarring, fainting, infection, needle sickness or broken needle. Occasionally a treatment can produce a temporary flare-up of symptoms, but these are almost always limited to no more than a few days. Awareness of the patient's condition can avert most harms. The risks of moxa use can be averted by good technique and communication with the patient. Fainting can be most easily avoided if the patient takes care not to come for treatment when he or she is exhausted, tired or hungry. Fainting also can be avoided by working with breath, guided movement, and proper positioning on the table. To avoid needle breakage, patients must limit their movement while on the table and be careful if needles are legally permitted out of the practitioner's range. Timely needle removal and instructions regarding such while the patients are at home can avert infection. By following the instructions of the acupuncture practitioner before and after treatment, the patient can avoid difficulty.

The acupuncture practitioner must be advised if the patient has a pacemaker or bleeding disorder, might be pregnant or has a contagious disease. Patients who take blood thinners such as coumadin (warfarin) should probably not get acupuncture, due to the increased risk of internal bleeding.

CONSENT FOR ACUPUNCTURE TREATMENT

I am hereby advised to consult with my primary care medical physician on medical issues and that acupuncture, oriental medicine or alternative care is not substituting for appropriate medical advice and care from a medical doctor.

By voluntarily signing below, I show that I have read, or have read to me, this consent to treatment, have been told the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Printed Name_____

Signature_____ Date_____

New York Sports Acupuncture
Bishara Wilson, DACM, L.Ac.
7 Marcus Garvey Blvd, Suite 429
Brooklyn, NY 11206
888.375.5444

Consent for Purposes of Treatment, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by New York Sports Acupuncture P.C. (hereafter noted as NYSA) for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at *Balance* may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. NYSA is not required to agree to the restrictions that I may request. However, if NYSA agrees to a restriction that I request, the restriction is binding upon NYSA.

I have the right to revoke this consent, in writing, at any time except to the extent that *Balance* has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review NYSA's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of NYSA. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at https://www.newyorksportsacupuncture.com/patient-forms/. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and NYSA with respect to my identifiable health information.

NYSA reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name and Relationship

New York Sports Acupuncture

Bishara Wilson, DACM, L.Ac.
7 Marcus Garvey Blvd, Suite 429, Brooklyn, NY 11206
888.375.5444

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____
BIRTHDATE _____ **SOCIAL SECURITY #** _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient:
X_____ _____ _____
Patient Signature or Legal Representative **Date** **Witness Signature**

Office Use Only:
☐ Accepted _____ _____ _____
☐ Denied Signature Title Date

ASSIGNMENT OF BENEFITS FORM

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to ***New York Sports Acupuncture, P.C.*** for any medical services provided to me by ***New York Sports Acupuncture, P.C***.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance carrier or other medical entity. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance company or other entity if requested. The original will be kept on file by ***New York Sports Acupuncture, P.C.***

I understand that I am financially responsible to the ***New York Sports Acupuncture, P.C.*** for any charges not covered by health care benefits. It is my responsibility to notify ***New York Sports Acupuncture, P.C.*** of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by ***New York Sports Acupuncture, P.C.*** and/or my health care insurer if the submitted claims or any part of them are denied for payment.

I understand that by signing this form I am accepting financial responsibility as explained above for all payment for products received.

By signing this document, I also acknowledge that I have received a copy of the organization's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my privacy rights.

Name of person signing below (print): _____

Relationship to Insured: _____

Signature of Insured or Parent/Guardian:

_____

Date: _____