PALMS
ACUPUNCTURE
&
WELLNESS
JUPITER FLORIDA

Medical In-Take Form

Personal Information

TODAY'S DATE _____

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ LAST 4 DIGITS OF YOUR SOCIAL SECURITY # _____

EMAIL ADDRESS _____ PHONE NUMBER _____ GENDER ◯ MALE ◯ FEMALE

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

EMERGENCY CONTACT _____ RELATIONSHIP TO YOU _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

Person Responsible For Payment (IF SOMEONE OTHER THAN YOURSELF)

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____ PHONE NUMBER _____

RELATIONSHIP TO YOU _____

Insurance Information

PRIMARY INSURANCE _____ POLICY # _____ GROUP# _____

PRIMARY INSURANCE POLICY HOLDER (SELF OR OTHER) _____

(IF OTHER) NAME _____ RELATIONSHIP TO YOU _____ DOB _____

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY PRIMARY CARE OR REFERRING PHYSICIAN, TO CONSULTANTS IF NEEDED AND AS NECESSARY TO PROCESS INSURANCE CLAIMS, INSURANCE APPLICATIONS, AND PRESCRIPTIONS. I ALSO AUTHORIZE PAYMENTS OF MEDICAL BENEFITS TO PALMS ACUPUNCTURE AND WELLNESS.

PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. I HAVE HAD A CHANCE TO READ OVER THE FINANCIAL RESPONSIBILITY FORM.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

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Medical History Form

Personal Information

TODAY'S DATE _____

FIRST NAME _____ LAST NAME _____ MIDDLE INITIAL _____

Past Medical History

PLEASE CHECK ALL THAT APPLY

- ◯ ANXIETY
- ◯ ARTHRITIS
- ◯ ARTERIAL FIBRILLATION
- ◯ BREAST CANCER
- ◯ COLON CANCER
- ◯ COPD
- ◯ CORONARY ARTERY DISEASE
- ◯ DEPRESSION
- ◯ DIABETES
- ◯ RENAL DISEASE
- ◯ GERD (INFLUX)
- ◯ HEARING LOSS
- ◯ HEPATITIS
- ◯ HIGH BLOOD PRESSURE
- ◯ HIV / AIDS
- ◯ HIGH CHOLESTEROL
- ◯ LEUKEMIA
- ◯ LUNG CANCER
- ◯ LYMPHOMA
- ◯ PROSTATE CANCER
- ◯ RADIATION TREATMENT
- ◯ SEIZURES
- ◯ STROKE
- ◯ HYPOTHYROID
- ◯ HYPERTHYROID

◯ OTHER _____

Medications

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Social History

PLEASE CHECK ALL THAT APPLY

CIGARETTE SMOKING
- ◯ DAILY
- ◯ SOME DAYS
- ◯ FORMER SMOKER
- ◯ NEVER SMOKED

OPTIONAL
- ◯ NOT SEXUALLY ACTIVE
- ◯ SEXUALLY ACTIVE
  - ◯ 1 PARTNER
  - ◯ MORE THAN 1 PARTNER
  - ◯ SAME SEX PARTNER

- ◯ DRUG USE
- ◯ IV DRUG USE

ALCOHOL USE
- ◯ NONE
- ◯ 1 DRINK PER DAY
- ◯ 2 DRINKS PER DAY
- ◯ 3 OR MORE DRINKS PER DAY

Pharmacy Information

PHARMACY NAME _____ LOCATION _____ PHONE _____

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Acupuncture Informed Consent To Treat

I HERBY REQUEST AND CONSENT TO THE PERFORMANCE OF ACUPUNCTURE TREATMENTS AND OTHER PROCEDURES WITHIN THE SCOPE OF THE PRACTICE OF ACUPUNCTURE ON ME (OR ON THE PATIENT NAMED BELOW, FOR WHOM I AM LEGALLY RESPONSIBLE) BY THE ACUPUNCTURIST NAMED BELOW AND/OR OTHER LICENSED ACUPUNCTURISTS WHO NOW OR IN THE FUTURE TREAT ME WHILE EMPLOYED BY, WORKING OR ASSOCIATED WITH OR SERVING AS BACK-UP FOR THE ACUPUNCTURIST NAMED BELOW, INCLUDING THOSE WORKING AT THE CLINIC OR OFFICE LISTED BELOW OR ANY OTHER OFFICE OR CLINIC, WHETHER SIGNATORIES TO THIS FORM OR NOT.

I UNDERSTAND THAT METHODS OF TREATMENT MAY INCLUDE, BUT ARE NOT LIMITED TO, ACUPUNCTURE, MOXIBUSTION, CUPPING, ELECTRICAL STIMULATION, TUI-NA (CHINESE MASSAGE), CHINESE HERBAL MEDICINE, AND NUTRITIONAL COUNSELING. I UNDERSTAND THAT THE HERBS MAY NEED TO BE PREPARED AND THE TEAS CONSUMED ACCORDING TO THE INSTRUCTIONS PROVIDED ORALLY AND IN WRITING. THE HERBS MAY BE AN UNPLEASANT TASTE OR SMELL. I WILL IMMEDIATELY NOTIFY A MEMBER OF THE CLINICAL STAFF OF ANY UNANTICIPATED OR UNPLEASANT EFFECTS ASSOCIATED WITH THE CONSUMPTION OF THE HERBS.

I HAVE BEEN INFORMED THAT ACUPUNCTURE IS A GENERALLY SAFE METHOD OF TREATMENT, BUT THAT IT MAY HAVE SOME SIDE EFFECTS INCLUDING BRUISING, NUMBNESS OR TINGLING NEAR THE NEEDLING SITES THAT MAY LAST A FEW DAYS, AND DIZZINESS OR FAINTING. BRUISING IS A COMMON SIDE EFFECT OF CUPPING, UNUSUAL RISKS OF ACUPUNCTURE INCLUDE SPONTANEOUS MISCARRIAGE, NERVE DAMAGE AND ORGAN PUNCTURE, INCLUDING LUNG PUNCTURE (PNEUMOTHORAX). INFECTION IS ANOTHER POSSIBLE RISK, ALTHOUGH THE CLINIC USES STERILE DISPOSABLE NEEDLES AND MAINTAINS A CLEAN AND SAFE ENVIRONMENT. BURNS AND/OR SCARRING A POTENTIAL RISK OF MOXIBUSTION AND CUPPING. I UNDERSTAND THAT WHILE THIS DOCUMENT DESCRIBES THE MAJOR RISKS OF TREATMENT, OTHER SIDE EFFECTS MAY OCCUR. THE HERBS AND NUTRITIONAL SUPPLEMENTS (WHICH ARE FROM PLANT, ANIMAL AND MINERAL SOURCES) THAT HAVE BEEN RECOMMENDED ARE TRADITIONALLY CONSIDERED SAFE IN THE PRACTICE OF CHINESE MEDICINE, ALTHOUGH SOME MAY TOXIC IN LARGE DOSES. I UNDERSTAND THAT SOME HERBS MAY BE INAPPROPRIATE DURING PREGNANCY. SOME POSSIBLE SIDE EFFECTS OF TAKING HERS ARE NAUSEA, GAS, STOMACH ACHE, VOMITING, HEADACHE, DIARRHEA, RASHES, HIVES AND TINGLING OF THE TONGUE. I WILL NOTIFY A CLINICAL STAFF MEMBER WHO IS CARING FOR ME IF I AM OR BECOME PREGNANT.

I DO 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 UPON THE FACT THEN KNOWN IS IN MY BEST INTEREST. I UNDERSTAND THAT RESULTS ARE NOT GUARANTEED.

I UNDERSTAND THE CLINICAL AND ADMINISTRATIVE STAFF MAY REVIEW MY PATIENT RECORDS AND LAB REPORTS, BUT ALL MY RECORDS WILL BE KEPT CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT MY WRITTEN CONSENT.

BY VOLUNTARILY SINGING BELOW, I SHOW THAT I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE 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 TREATMENTS FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK TREATMENT.

SIGNATURE _____ DATE _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

INDICATE RELATIONSHIP IF SIGNING FOR PATIENT

PALMS
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Injection Consent

NAME _____ DATE OF BIRTH _____ AGE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

WHO MAY WE THANK FOR REFERRING YOU? _____

EMAIL ADDRESS _____
MAY WE EMAIL YOU SPECIALS? ◯ YES ◯ NO

EMERGENCY CONTACT _____ PHONE _____

LIST ALL MEDICATIONS AND / OR SUPPLEMENTS, INCLUDING HERBS AND VITAMINS YOU ARE CURRENTLY TAKING (FEEL FREE TO BRING A COPY OF YOUR MEDICATION LIST TO YOUR APPOINTMENT)

ARE YOU CURRENTLY ILL WITH A COLD OR THE FLU? ◯ YES ◯ NO
ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING? ◯ YES ◯ NO
HAVE YOU PREVIOUSLY HAD AN INJECTION? ◯ YES ◯ NO

I AM REQUESTING AN INJECTION.

I UNDERSTAND WITH ALL INJECTIONS, THEY MAY CAUSE PAIN OR REDNESS AT THE SITE OF INJECTION ALTHOUGH THIS IS RARE. SOMETIMES YOU MAY ALSO BRUISE AT THE SITE OF INJECTION. IF YOU HAVE ANY CONCERNS AFTER THE INJECTION WITH SWELLING OR REDNESS, PLEASE CALL THE OFFICE IMMEDIATELY. IF IT IS AFTER HOURS, PLEASE GO TO THE EMERGENCY ROOM IF YOU ARE HAVING DIFFICULTY BREATHING OR ANY OTHER SERIOUS REACTIONS.

I CERTIFY THAT EVERYTHING ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE _____ DATE _____

ACUPUNCTURIST SIGNATURE _____ DATE _____
DENISE JACOBS, DOM

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Financial Policy

THANK YOU FOR CHOOSING US AS YOUR HEALTH CARE PROVIDER. WE ARE COMMITTED TO YOUR TREATMENT BEING SUCCESSFUL. PLEASE UNDERSTAND THAT PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR TREATMENT, THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, WHICH WE REQUIRE YOU TO READ AND SIGN PRIOR TO ANY TREATMENT.

ALL PATIENTS MUST COMPLETE OUR PATIENT INFORMATION SHEET BEFORE SEEING THE DOCTOR.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, AMERICAN EXPRESS AND DISCOVER.

REGARDING INSURANCE

WE WILL VERIFY COVERAGE PRIOR TO TREATMENT. AS A COURTESY, WE WILL ALSO PROVIDE YOU WITH A SUPER-BILL AT THE END OF EACH MONTH. OUR FEES ARE DETERMINED BY THE COMPLEXITY OF THE PARTICULAR CASE AND THE DIFFERENT SERVICES USED DURING TREATMENT. ANY BALANCE DUE ON YOUR TREATMENTS IS YOUR RESPONSIBILITY WHETHER YOUR INSURANCE COMPANY PAYS OR NOT. WE DO NOT BILL YOUR INSURANCE COMPANY. YOUR INSURANCE POLICY IS CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT PARTY TO THAT CONTRACT. IN SIGNING THIS DOCUMENT, YOU UNDERSTAND THIS OFFICE DOES NOT BILL INSURANCE. ADDITIONALLY IN SIGNING THIS DOCUMENT YOU AUTHORIZE THE RELEASE OF ANY INFORMATION TO ANY INSURANCE COMPANY, ADJUSTOR OR ATTORNEY THAT WILL ASSIST IN THE PAYMENT OF A CLAIM.

USUAL AND CUSTOMARY RATES (UCR)

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT POSSIBLE FOR OUR PATIENTS. WE CHARGE WHAT IS USUAL AND CUSTOMARY FOR OUR AREA. PLEASE BE AWARE THAT SOME AND AT TIMES PERHAPS ALL OF THE SERVICES PROVIDED MAY BE "NON-COVERED" SERVICES AND NOT CONSIDERED REASONABLE AND NECESSARY UNDER THE MEDICARE PROGRAM AND/OR BY OTHER MEDICAL INSURANCE. YOU ARE RESPONSIBLE FOR PAYMENT IN FULL REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY DETERMINATION OF USUAL AND CUSTOMARY RATES.

MISSED APPOINTMENTS

UNLESS CANCELED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT THE RATE OF A NORMAL OFFICE VISIT. YOUR TREATMENTS WILL BE MORE EFFECTIVE IF YOU FOLLOW YOUR DOCTOR'S GUIDELINES AND STICK TO YOUR TREATMENT SCHEDULE. PLEASE HELP US SERVE YOU BETTER BY KEEPING SCHEDULED APPOINTMENTS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE NAY QUESTIONS OR CONCERNS.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

SIGNATURE DATE

_____ _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

A PHOTOCOPY OF THIS FORM SHALL BE CONSIDERED AS EFFECTIVE AS THE ORIGINAL

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Notice Of Privacy Policies

THE FOLLOWING IS THE PRIVACY OF PALMS ACUPUNCTURE & WELLNESS AS DESCRIBED IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) OF 1996. HIPPA REQUIRES PALMS ACUPUNCTURE & WELLNESS BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF PALMS ACUPUNCTURE & WELLNESS'S LEGAL DUTIES AND PRIVACY POLICIES WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION.. WE ARE REQUIRED BY LAW TO ABIDE BY THE TERMS OF THIS PRIVACY NOTICE.

YOUR PERSONAL HEALTH INFORMATION
WE COLLECT PERSONAL HEALTH INFORMATION FROM YOU THROUGH TREATMENT, PAYMENT AND RELATED HEALTHCARE OPERATIONS, THE APPLICATION AND ENROLLMENT PROCESS, AND/OR HEALTHCARE PROVIDERS OR HEALTH PLANS, OR THROUGH OTHER MEANS, AS APPLICABLE. THE LAW SPECIFICALLY PROTECTS HEALTH INFORMATION THAT CONTAINS DATA, SUCH AS YOUR NAME, ADDRESS, SOCIAL SECURITY NUMBER, AND OTHERS, THAT COULD BE USED TO IDENTIFY YOU AS THE INDIVIDUAL PATIENT WHO IS ASSOCIATED WITH THAT HEALTH INFORMATION. THIS OFFICE MAY SEND BIRTHDAY CARDS, NEWSLETTERS AND APPOINTMENTS REMINDERS (TELEPHONE, TEXT, EMAIL, LETTER, ETC.)

USES OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION
GENERALLY, WE MAY NOT USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION WITHOUT YOUR PERMISSION. THE FOLLOWING ARE THE CIRCUMSTANCES UNDER WHICH WE ARE PERMITTED BY LAW TO USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION.

AS REQUIRED BY LAW. WE MAY USE OR DISCLOSE YOUR PERSONAL HEALTH INFORMATION TO THE EXTENT THAT SUCH USE OR DISCLOSURE IS REQUIRED BY LAW AND THE USE OR DISCLOSURE COMPLIES WITH AND IS LIMITED TO THE RELEVANT REQUIREMENTS OF SUCH LAW.

YOUR RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION
UNDER HIPPA, YOU HAVE CERTAIN RIGHTS WITH RESPECT TO YOUR PERSONAL HEALTH INFORMATION. IT IS YOUR RIGHT TO REQUEST THE FOLLOWING REGARDING YOUR PERSONAL HEALTH INFORMATION:

- RIGHT TO REQUEST RESTRICTIONS ON USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.
- RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS.
- RIGHT TO INSPECT AND COPY YOUR PERSONAL HEALTH INFORMATION.
- RIGHT TO REQUEST AMENDMENT OF YOUR PERSONAL HEALTH INFORMATION.
- RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION.

YOU MAY FILE A COMPLAINT WITH US AND WITH THE SECRETARY OF DH'S IF YOU BELIEVE THAT YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED. COMPLAINTS FILED WITH THE SECRETARY OF DH'S MUST BE FILED WITHIN 180 DAYS OF WHEN YOU KNEW OR SHOULD HAVE KNOWN THAT THE ACT OR OMISSION COMPLAINED OF OCCURRED.

US DEPARTMENT OF HEALTH AND HUMAN SERVICES
DHHS (OFFICE OF CIVIL RIGHTS)
200 INDEPENDENCE AVE SW ROOM 509 BUILDING F
WASHINGTON, DC 20201

IF YOU HAVE ANY QUESTIONS OR WANT MORE INFORMATION REGARDING HIPPA, PLEASE CONTACT US.

SIGNATURE _____ DATE _____

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

INDICATE RELATIONSHIP IF SIGNING FOR PATIENT