Jaime Marks Acupuncture PLLC

Health History Questionnaire

Please help us provide you with a complete evaluation by filling out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

Name____________________________ Sex____________________ Date_______________________

Address____

Date of Birth_____________________

Telephone: Best ( )____________________________ email________________

Occupation ______________________

Have you had acupuncture treatments before? ____

Referred by____

Chief Complaint____

<u>Medical History of Chief Complaint</u>

Date of Onset_____________________

Have you experienced this before? ______________________________

Please list any previous treatments for this condition including any hospitalizations, surgeries, medications, physical therapy, exams, lab tests (blood analysis, X-Ray, MRI, etc.)

Does this condition interfere with your daily activities (work, exercise, sleep, etc.)

Medical doctor's name, address, and phone number: ____

____

Drugs: Prescription____

Over the counter___________________________

Vitamins and Herbs ____

Diet: (circle one) Good Bad Ugly

Food Cravings ____

Exercise ____

Jaime Marks Acupuncture PLLC

I. PATIENT ADVISORY TO CONSULT A PHYSICIAN

To comply with Article 160, Section 8211.1 (b) of the New York State Education law, I request that you read and sign the following statement:

I, the undersigned, do affirm that ______________ (patient) has been advised by Jaime S. Marks Acupuncture, to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

__________________________ _____________
Patient Signature Date

__________________________ _____________
Licensed Acupuncture Signature Date

II. INFORMED CONSENT TO ACUPUNCTURE TREATMENT

I consent to acupuncture treatments and other procedures associated with Traditional and Classical Chinese Medicine performed by Jaime Marks Acupuncture. I have discussed the nature and purpose of my treatments with the acupuncturist.

I understand that methods of treatment may include, but are not limited to acupuncture, moxibustion, cupping, electrical stimulation and Tui Na (Chinese Massage).

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 for 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 (pneumothorax). Infection is another possible risk, although Jaime Marks Acupuncture, L.Ac., uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. In rare cases a patient can feel worse after treatment

I will pay for fees at the time of service. I authorize the use of my credit card.

The herbs and nutritional supplements (which are from plant and mineral sources) that have been recommended are, traditionally considered safe in the practice of Chinese Medicine. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastrointestinal upset or allergic reactions to the herbs, I will inform the acupuncturist

I will notify Jaime Marks Acupuncture, if I am or become pregnant.

I do not expect Jaime Marks Acupuncture to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts known to him/her, is in my best interests.

I agree to assign benefits from my insurance company to Jaime Marks Acupuncture PLLC via check of electronic means of deposit.

I understand that all of my records will be kept confidential and will not be released to any party without my written consent.

By voluntarily signing below, I show that I have read, or have read to me, this 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 treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated)

____
Date of Consent

____
Print Name of Patient

______________________________ __________________________
Signature of Patient or Representative Jaime Marks Acupuncture, L.Ac

Jaime Marks Acupuncture
L.Ac., MSTOM

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________

Relationship to Patient: ______________________

Signature: ______________________

Date: ____________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Jaime Marks Acupuncture PLLC

Patient Financial Responsibility

- You, as a patient or guardian of the patient, are responsible for the cost of all services rendered.

- Insurance may no pay for certain services rendered, which will be the responsibility of the patient of guardian of the patient. The practitioner will try to notify you in advance of services that may not be covered by insurance, but the practitioner's failure to notify in advance will not relieve you of financial responsibility.

- If insurance eligibility cannot be verified prior to services being rendered, or if you do not have insurance, the full payment is due prior to the treatment.

- Deductibles, co-insurances, and co-payments are due at the time of your office visit.

- If your insurance plan requires a referral or prior authorization, you are required to receive that referral or prior authorization before treatment. If neither is received before treatment, full payment will be due in advance.

Cancellation Policy

- If you cancel your appointment with less than 24-hour notice, or you miss a booked appointment, you will be charged the full price of the appointment. As a courtesy, if there is another appointment available on the same day, we will offer you that time without applying the fee.

I understand my financial responsibility for services rendered.
Print Name:______________________________________
Signature:_______________________________________
Guardian Name:___________________________________
Guardian Signature:_______________________________
Date:____

COVID-19 Informed Consent to Treatment

I understand that the World Health Organization (WHO) has declared the novel Corona virus (COVID-19) a global pandemic. I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following:

- I understand my treatment may create circumstances such as the discharge of respiratory droplets or person -to-person contact, in which COVID-19 can be transmitted.
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care.
- I understand that I'm opting for an elective treatment that may not be urgent or medically necessary. I understand there are alternatives for receiving this care, which includes receiving care for another type of provider or postponing care at this time. However, while I understand the potential risks associated with receiving treatment during COVID-19 pandemic, I agree to proceed with treatment at this time.
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a healthcare office.
- I confirm I am not experiencing any of the following symptoms of COVID-19 listed below:
  *Fever *Dry cough *Sore throat
  * Runny nose *Shortness of breath *Loss of taste or smell
- I understand travel increases risk of contraction and transmitting COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) outside the US to countries that have been affected by COVID-19 or 2) Domestically within the US by commercial airline, bus, or train.

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

To be completed by patient (or patient's representative if the patient is a minor or is physically or legally incapacitated)

Patient's Name: ____ Date of Consent: _________

Signature of Patient or Representative: ___________________________________

Relationship to Patient: ____