Serene Care Clinic Patient Intake Form

Name _____ Date _____

Address _____

City _____ State_____ Zip _____

Phone (Home)_____ (Work) _____ Cell _____

Age _____ Date of Birth _____ Sex M ___ F ___ SS# _____

Married _____ Separated _____ Divorced _____ Widowed _____ Partnership _____ Single _____

Occupation _____ Hours per week _____

Employer Name _____

Employer Address _____

Emergency Contact _____

Phone _____ Relationship _____

Address _____

How did you hear about or who referred you to our clinic_____

General Medical Information

Chief Problem(s) _____

_____

Objective _____

_____

_____

_____

_____

_____

How long have you had this problem? _____

Does any family member have this problem?_____

Have you had this problem before? _____

Where is the problem? _____

Have you traveled recently? _____

Height _____Weight _____ Exercise Y___ N ___

If so, what kind and how often? _____

PLEASE LIST ALL YOUR MEDICATIONS: PRESCRIPTION, OVER THE COUNTER, VITAMINS OR OTHER SUPPLEMENTS.

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

ALLERGIES

Are you allergic or hypersensitive to:

Any drugs? _____

Any foods? _____

Any chemicals? _____

HOSPITALIZATIONS

Please bring copies of any reports for lab work, x-ray, EKGs, etc. that you have had done recently.

REASON FOR HOSPITALIZATION	YEAR	REASON FOR HOSPITALIZATION	YEAR
1		6	
2		7	
3		8	
4		9	
5		10	

Have you ever had a blood transfusion? Yes ___ No ___

If yes list approximate dates _____

DATE	SERIOUS ILLNESS/ INJURY	OUTCOME

PREGNANCIES

YEAR OF BIRTH	SEX OF BIRTH	COMPLICATIONS IF ANY

HEALTH HABITS

CHECK WHICH YOU USE AND AMOUNT OF USE.		
Alcohol		
Tobacco		
Street Drug		
Other		

FAMILY HISTORY

RELATIONSHIP TO YOU	AGE	STATE OF HEALTH	CAUSE OF DEATH	DISEASE	YES	RELATIONSHIP TO YOU
Father				Arthritis		
Mother				Asthma, Hay Fever		
Paternal Grandfather				Cancer		
Paternal Grandmother				Chemical Dependency		
Maternal Grandfather				Diabetes		
Maternal Grandmother				Heart Disease Or Stroke		
Brothers				High Blood Pressure		
				Kidney Disease		
Sisters				Tuberculosis		
				Other		

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness

MUSCLE, JOINT, BONE

- ☐
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders
- ☐

GENITAL-URINARY

- ☐
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Poor Appetite
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Poor Appetite

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High Blood Pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN ONLY

- ☐ Breast Lump
- ☐ Erection difficulties
- ☐ Lump in Testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN ONLY

- ☐ Abnormal Pap Smear
- ☐ Bleeding between
- ☐ Breast lump
- ☐ Extreme Menstrual Pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual Period _____

Date of Last Pap Smear _____

Have you had a Mammogram _____

Are you pregnant _____

Number of Children _____

CONDITIONS

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders

CONDITIONS cont.

- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Gonorrhea
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ HIV Positive
- ☐ Hernia
- ☐ Herpes
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my Doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

SERENE CARE CLINIC

INFORMED CONSENT FOR NATUROPATHIC MEDICINE, ORIENTAL MEDICINE AND ACUPUNCTURE

I hereby voluntarily consent to receive Naturopathic Medicine, Oriental Medicine and Acupuncture treatment for my present and future health condition.

Naturopathy: Naturopathic philosophy focuses on treating the whole person and strives to find the underlying cause of the patient's condition rather then focusing solely on symptomatic treatment. A naturopathic approach to healthcare focuses on taking the time to understand each patient's individual needs. With "the patient comes first" approach in a health care system the ND is able to recommend the most appropriate and comprehensive therapies the first time. Where the situation calls for, Naturopathic physicians also work with all other branches of medical science to provide the most thorough patient care.

Acupuncture: This is a safe treatment involving the insertion of tiny sterile disposable needles, through the skin, which can produce a mild but temporary discomfort (usually achiness or soreness) at the acupuncture site. It can occasionally cause slight bleeding and will rarely leave a bruise (not painful).Other possible risks from acupuncture include dizziness and fainting. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection however these have an extremely low incidence rate, especially when acupuncture is administered properly.

Traditional Chinese Herbal Supplements: Chinese herbs have been used safely for centuries. Infrequently one may experience digestive upset or other reactions to the herbs. If you experience any discomforts related to the use of herbs you should stop the herbs and inform the LAc of your symptoms. Some herbs may be inappropriate during pregnancy and breastfeeding. Please inform the LAc of suspected or confirmed pregnancy, or if you are a nursing mother.

Cupping: This involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising at the treated area. The bruising, which is not painful, virtually resolves in three to seven days.

Electro-acupuncture: A mild electric micro current similar to a TENS treatment, is used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt.

PRP Injection: To aid in healing tendon or ligament injuries by injecting Platelet Rich Plasma into the injured area.

Prolotherapy: A non-surgical ligament reconstruction by injecting a sugar based solution at the site of tendon to bone attachment.

By signing below I show that:

- I have read or had read to me, the information on this consent form.
- I understand the possible risks and complications involved.
- I have had the opportunity to discuss this consent form with my licensed acupuncturist.
- I understand that I can request more information at any time if desired.
- I consent to receiving treatment that involves the above procedures.
- I understand that I have the right to refuse any treatment at any time.
- I understand that this refusal may affect the expected results.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative | Relationship to Patient

SERENE CARE CLINIC

HEALTH INFORMATION PRIVACY RIGHTS

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law your health care provider generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health care providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your health care. It is important that you understand that your information can be used and shared in the following ways:

- For your treatment and care coordination. Multiple health care providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your health care or health care bills.
- To protect the public's health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

In order to provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

☐ Please do not phone me at home. Use this alternate phone number: _____

☐ Please do not phone me at work. Use this alternate phone number: _____

☐ Please do not leave messages on my answering machine.

☐ Please do not contact me by email.

☐ Please send mail, including my bills, to this alternate address:

_____

_____

☐ Other request (please describe):

_____

_____

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing one of the healthcare providers at Serene Care Clinic (SCC). We will do our best to provide you with the highest quality medical services. We feel that it is very important that our patients have a clear understanding of our expectations regarding billing and payment. Please read and sign the following Financial Policy prior to your visit, and please ask if you have questions.

INSURANCE

SCC's healthcare providers are contracted with many healthcare insurance, worker's compensation and motor vehicle accident plans. SCC will bill them directly once we verify your coverage, if services at SCC are not covered, you are responsible for any balance left after payment and/or denial.

CO-PAYMENTS AND DEDUCTIONS

If your policy has an office visit co-payment, you must agree to pay the co-payment at the time of your visit. Failure to do so will result in an additional $15.00 fee. **Patients are responsible to know the terms of their insurance and whether services are covered.**

PATIENTS WITHOUT INSURANCE

The full balance is due upon checkout. ***We do offer a discounted cash prices for services, and please refer to our price list.***

ALTERNATIVE BENEFITS

Many of services we offer can be considered an alternative therapy that may or may not be covered by your insurance. We will verify your coverage before your scheduled appointment if the insurance information is provided 48 hours ahead of the appointment. It is your responsibility to pay full cash prices when your insurance status was not verified before your appointment. Even though our providers may be contracted with your insurance, there are provider specialties and services that can be excluded on insurance plans.

ADDITIONAL CHARGES AND FEES

For any check that is returned for non-sufficient funds, SCC will charge an additional $35.00 to your account and we will not accept your personal checks in the future. You will be asked to remit the amount of the check plus the service charge in cash or with a credit card payment within 10 days. If your account has not cleared by then, we will refer it for collection action.

Patients that "no show" or do not cancel 24 hours prior to their appointment time may be assessed an appointment charge of $25. This charge is your responsibility.

When a child of divorced parents is seen, we will expect payment from whichever parent accompanies that child. We will not bill ex-spouses or the other parent.

If you are having financial difficulty, we will be happy to work with you. You may want to establish a payment plan. We ask that these payments are made as scheduled, each month and on time. We do monitor these accounts and non-payment may jeopardize your ability to be seen by our physicians.

Name of responsible party (if other than the patient):

_____

Relationship to the patient: _____ Phone#: _____

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Serene Care Clinic to release information necessary to secure payment.

_____ _____

Signature Date