PLEASE FILL OUT THIS FORM, SAVE A COPY, AND EMAIL TO INFO@AMITYVILLEWELLNESS.COM

Amityville Wellness
631.691.0200
live life in balance.

www.amityvillewellness.com

*First Name _____ *Last Name _____ Date _____

*Address _____ *City _____

*State _____ *Zip Code _____ Occupation _____

*Home Phone _____ *Cell Phone _____

*Email address for appointment reminders _____

*Emergency contact _____ *Phone _____ *Relationship _____

If you will be using any form of insurance include your SSN

*Who can we thank for referring you?

☐ Provider Name and Phone number _____

☐ Friend or Family member _____

☐ Other

Sex Female Height *Birth date _____ Age

Marital Status Number of Children

*Previous Acupuncture? _____ *When? _____ *With Whom? _____

*What are the main health problems for which you are seeking treatment?

*What other forms of treatment have you sought?

* Required

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Indicate significant illnesses you or a blood relative (grandparent, parent or sibling) have had:

Illness	You	Relative	Illness	You	Relative
Cancer	☐	☐	Diabetes	☐	☐
Hepatitis	☐	☐	Heart Disease	☐	☐
High Blood Pressure	☐	☐	Seizures	☐	☐
Rheumatic Fever	☐	☐	Emotional Disorders	☐	☐
Gonorrhea	☐	☐	Tuberculosis	☐	☐
HIV	☐	☐	Syphilis	☐	☐
Clamydia	☐	☐	PV	☐	☐
Herpes	☐	☐			

If you indicated a significant illness above, provide details including the date and treatment:

List any other accidents, surgeries or hospitalizations (include date):

List any other health problems you now have:

Please indicate the use and frequency of the following:

	Y/N	Amount		Y/N	Amount
Coffee/Black Tea	☐		Water Intake	☐	
Tobacco	☐		Alcohol	☐	
Recreational Drugs	☐		Soda Pop	☐	

I am taking blood thinners ☐ I have a pacemaker ☐

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List any medications and supplements you are currently taking: (continue on back if needed)

Medication	Dosage	Reason	How Long	Prescribed by	Date last check up

List any allergies, food sensitivities or food cravings that you have:

How do you FEEL about the following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your Comments
Diet	☐	☐	☐	☐	☐	
Exercise	☐	☐	☐	☐	☐	
Work	☐	☐	☐	☐	☐	
Sex	☐	☐	☐	☐	☐	
Self	☐	☐	☐	☐	☐	
Significant Other	☐	☐	☐	☐	☐	
Family	☐	☐	☐	☐	☐	
Spirituality	☐	☐	☐	☐	☐	

----------For Women----------

Age of first period (menarche)	_____	Age of last period (menopause)	_____
Are you pregnant?	_____	# of Pregnancies	_____
# of live births	_____	# of Abortions	_____ # of Miscarriages _____
Date of last Gynecological exam	_____	Pap Smear	_____
Mammogram	_____	Bone Density Scan	_____
Number of days between periods		Number of days flow	

----------For Men----------

Date of last prostate check-up	PSA Results

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Informed Consent to Treat

I, hereby request and consent to the performance of acupuncture and massage treatments and other procedures within the scope of the practice of acupuncture and/or massage on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist/massage therapist and/or other licensed acupuncturist/ massage therapist who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist/massage therapist, including those working at the clinic or office listed below or any other office of clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, massage therapy, moxibustion, cupping, electrical stimulation, Tiu-Na (Chinese medicine), 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 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 and massage 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 clinical uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks 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 be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs 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 not 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 judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts 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 signing 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 treatment for my present condition and for any future conditions for which I seek treatment.

Name of person signing below (print): _____ Relationship _____

Signature of Patient or Parent/Guardian: _____ Date _____

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Privacy Policy and Assignment of Benefits Form

Name of Patient:			
Primary Insurance:		Secondary Insurance:	
Policy Holder:		Policy Holder:	
Policy Holder's DOB:		Policy Holder's DOB:	
Relationship to Policy Holder:		Relationship to Policy Holder:	
ID Number:		ID Number:	
Social Security #			

I request that payment of authorized insurance benefits be made on my behalf to the organization listed below for any services provided to me by that organization. I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to the organization, my insurance carrier, or other medical entity. A copy of this authorization will be sent to my insurance company or other entity if requested. The original authorization will be kept on file by the organization.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization 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 the organization 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 services 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.

ORGANIZATION

Amityville Acupuncture and Wellness
209 Broadway
Amityville, NY 11701

If you would like any other person(s) to have access to your medical records, please fill out the following:

I authorize release of my medical information and records to the following person(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name of person signing below (print): _____ Relationship _____

Signature of Patient or Parent/Guardian: _____ Date _____

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Office and Payment Policies

At Amityville Wellness, we require keeping a credit or debit card on file as a convenient method of payment for treatments, copays, coinsurance and product purchases. Your credit card information is kept confidential and secure and payments to your card are only processed at the time of treatment.

If it is necessary to cancel your scheduled appointment, we require that you contact us at least 24 hours in advance. Failure to be present at the time of a scheduled appointment, will result in a charge of $30.00 to the credit card on file. As a courtesy we send text message and email reminders when possible. It is your duty as a patient to arrive promptly to your scheduled appointment.

Co-payments, co-insurance, and deductibles are due at the time of your visit. We accept cash, check, and most credit cards. Any differences will be charged or refunded to you.

Some Health plans require that payment be made to the member directly. To properly insure payment of your account, it will be your responsibility to bring those payments to our office. This should include the original signed insurance check and the original or copy of the explanation of benefits. (This helps us to credit your account properly)

Your benefits are based on a contract between you, your insurance company, and your employer. Benefits vary and may change from time to time and not all services may be covered. We cannot reduce or waive any co-payments/co-insurance/ deductibles. Your insurance company determines your co-payment/co-insurance/deductible, not our office. You can contact your insurance company with any questions related to your coverage.

All returned checks will be charged a $30 fee along with the amount that you originally owe.

You are responsible to let our office know of any changes in address, phone numbers, and/or insurance information.

A fee of $0.75 per copy will be charged to patients if any copies of medical records are needed. A $5 fee will be charged for any paperwork to be filled out by the therapist.

You are responsible for responding promptly to any request from us or your insurance company to provide any additional information required from you. Any claims unpaid due to your failure to provide the information requested in a timely fashion will be your responsibility and must be paid in full.

We are not responsible for lost or stolen personal items.

If you should have any questions regarding the above information, please contact our office.

Print Name: _____

Signature: _____ Date: _____

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Media & Social Release Form

As a part of a vibrant company, we like to promote patient and office activities and celebrate achievements from time to time. For example, we might make a Social Media post like: Testimonials and event photos.

I, _____ (please print), do hereby grant permission to Amityville Wellness to post my photo, first name, and/or other items pertaining to treatment success to their Facebook, Snapchat, Instagram, or other Social Media pages. The Health Insurance Portability and Accountability Act still holds its place and I have been informed that absolutely no medical records will be released with the signing of this form.

We acknowledge that any patients that are under 18 years of age may not sign this without their parent present or parent's permission. If you are a parent signing for your child please enter their name in the space provided below.

Patient's Name: _____ Date: _____

Patient or Parent Signature: _____ Date: _____