ANCIENT WISDOM HEALING ARTS
Acupuncture & Herbal Clinic

Dr. Jacob Wilcox, DOM
Dr. Nayeli Navarro, DOM
Dr. Adam Broder, DOM
1301 S. Saint Francis Dr, Suite C
Santa Fe, NM 87505
P: (505) 210.2781 F: (505) 303.3176
AncientWisdomHealingArts.com

CONFIDENTIAL PATIENT INFORMATION

Today's Date _____

Personal Information

First Name _____ Last Name _____ MI _____

What do you prefer to be called? _____ Birth Date _____/_____/_____ Sex ☐ M ☐ F ☐ Other

Address _____ City_____State_____Zip_____

Cell Phone _____ Home/Secondary Phone_____

Email Address _____ ☐ Check here if you do NOT wish to receive our monthly newsletter.

Whom may we thank for referring you? _____

Emergency Contact:

Name _____ Relationship _____ Phone number _____

Insurance Information

Insurance Co. Name_____ID # _____Group #_____

Policy Holder Name _____DOB ___/___/____ Relationship to Patient _____

Main Complaint Information

What health concern(s) would you like help with? _____

_____

_____

When did you first notice symptoms? _____

_____

Have you been given a diagnosis for this problem? If so, what? _____

What kinds of treatments/therapies have you tried? _____

_____

Have they helped alleviate the condition/problem? _____

_____

Are you currently receiving other treatment for this problem? _____ If so, please describe _____

_____

Do you have any other problems you would like us to be aware of? _____

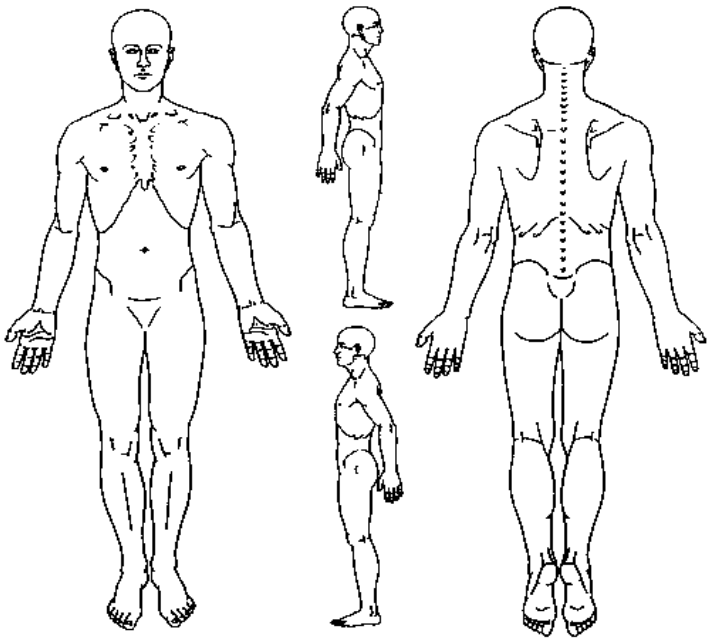
_____

_____

Please list all healthcare practitioners whose care you have received within the last 12 months _____

_____

Please mark painful or distressed areas on the diagrams below, if applicable



Symbol	Reaction
Pain	
X	little
XX	moderate
XXX	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Pulsing	
O	slight
OO	moderate
OOO	strong
Weakness/Temperature	
~	weak
+	hot
Skin Problems	
*	skin issue

Lifestyle

Occupation _____ Employer _____

Current quality of life _____

Any unusual stress lately? _____

Any anxiety, depression or other emotional issues? If so, please describe _____

_____

How is your energy? _____ How is your appetite? _____

Any digestive issues? If so, please describe _____

Describe your daily diet _____

_____

_____

Bowel movements: How often? _____ Please note anything unusual _____

Any urination issues? _____

Do you have trouble sleeping? If so, please describe _____

Women's Health

Are you pregnant? _____□ Trying □ Maybe Birth Control _____

Number of: Pregnancies _____ Births _____ Miscarriages _____

Age of first menses _____ Date of last menses _____ Any Menopausal Signs_____

Length of cycle (days)? _____ Durations of flow? _____

Any other gynecological concerns or issues? _____

_____

Hysterectomy: □Yes □No Date _____ Reason _____

_____

Health History

Please list your medical history with dates. Please include any other significant illness or ailments past or current. Also list any accidents, hospitalizations, and surgeries. _____

Medications / Allergies

List all medications you are now taking or have taken in the last 3 months, including prescriptions, over the counter medications, vitamins, herbs, etc.

Name	Reason for taking	Dosage	How long

Please list all allergies: medications, foods, environmental, etc. _____

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CONSENT FOR TREATMENT

I hereby request and voluntarily consent to receiving acupuncture treatments which consist of inserting fine, sterile needles through the skin into the underlying tissues. An acupuncture treatment may also involve treatment modalities that may be unfamiliar. **I understand I have the right to informed consent prior to being treated with them and I have the right to refuse any modality at any time for any reason.** These modalities may include, but are not limited to, the use of cuppng, gua sha, heat therapy, tui na (Chinese massage), electrical stimulations, diet and nutritional counseling, and herbal products (raw and prepared forms).

I fully understand that the risks of acupuncture treatments, although limited and rare, could include the following: minor bruising and burns, minor pain at the needle site, dizziness or faintness. I understand and accept these risks involved in treatment.

If I use a pacemaker, am taking drugs, supplements, and/or herbs I agree that I will inform the practitioner before beginning the treatment.

Initial here _____ Pregnancy: I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner omits points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that because acupuncture works within the entire body to restore balance, acupuncture may affect people on all levels: physical, emotional, mental, and spiritual. I do not expect the Doctor of Oriental Medicine to be able to anticipate and explain all possible risks and complications of treatment. I understand that the duration of treatment varies from person-to-person depending on the specific illness and body constitution. I fully understand that there is no stated or implied guarantee of success or effectiveness after a specific treatment or series of treatments. I state that I have completed the patient health history form completely and accurately. **I have been informed that I have a right to refuse any form of treatment or to stop treatment at any time for any reason.**

_____ _____
Patient Signature (or authorized representative) Date

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FINANCIAL AGREEMENT & APPOINTMENT CANCELLATION POLICY

We would like to take a moment to welcome you to our office and familiarize you with our financial policy and your responsibilities.

Payment for Services:
Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. Returned checks will be charged a $30 fee.

Explanation of Insurance Coverage:
Many insurance policies do cover acupuncture care, but this office makes no representation that yours does. As a courtesy, our office may verify your coverage with your insurance company, however, it is your responsibility to understand your coverage and benefits, including services covered, deductibles, copayments and coinsurance percentages, and medical necessity requirements. *If for any reason your insurance denies coverage for your treatments, you are personally responsible for full payment for all services rendered.*

Many insurance policies limit the number of acupuncture treatments that are covered in a calendar year, and some combine those limits with massage and chiropractic.
**It is your responsibility to keep track of the number of visits you have used each year. You will be billed for all visits over your insurance's limit at our standard rate.*

Release of Information/Assignment of Benefits:
If your insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the medical information necessary to process your claims. By signing below you also assign directly to Ancient Wisdom Healing Arts all insurance benefits otherwise payable to you for services rendered.

Appointment Cancellation Policy:
Please be aware that a specific amount of time has been set aside for your treatment. Arriving late means that your treatment will be adjusted to fit into the time scheduled, or it will be rescheduled. We require 24 hours' notice of intent to cancel or reschedule your appointment, except in case of emergencies.
**Missed or late-cancelled appointments will be charged a $50.00 cancellation fee.*

My signature below constitutes acknowledgement and acceptance of these policies.

_____ _____
Patient Signature (or authorized representative) Date

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Acknowledgement of Receipt of Privacy Practices

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:
a) Treatment -To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care -We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:
a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____ _____
Signature of patient or representative Date

_____ _____
Print patient name Patient Date of Birth