THE CENTER FOR
SPINE, SPORT & PHYSICAL MEDICINE

New Patient Intake Form

Name: _____ Date: _____

Address: _____ Birth Date: _____ /_____/_____

City: _____ State: ____ Zip _____ SS#: _____-_____-_____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

I give The Center for Spine, Sport and Physical Medicine permission to leave messages pertaining to my appointment. □Yes □ No

Home: _____ Cell Phone: _____

Work Phone: _____ E-mail:_____

How did you hear about us? _____

Emergency Contact:_____ Relationship:_____

Phone #:_____

INSURANCE INFORMATION:

Insurance Company: _____
ID #:_____Group # (Include any letters):_____
Primary Policy Holder's Name: _____ Policy holders DoB: _____/_____/_____
Relationship to policy holder: □ Self □ Spouse □ Child

Secondary Insurance Company: _____
ID #:_____Group # (Include any letters):_____
Primary Policy Holder's Name: _____ Policy holders DoB: _____/_____/_____
Relationship to policy holder: □ Self □ Spouse □ Child

Did this condition arise as a result of a motor vehicle accident or work injury? No_____ Yes_____
Claim #:_____ Date of injury: _____/_____/_____
Adjuster's Name: _____ Phone#: _____
Claims address: _____

Have you retained an attorney? No___ Yes___ Please provide name and contact information below:

Acupuncture Health History:

Family Physician: _____ Referred By: _____

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

What is your main health concern that has brought you to our clinic?

1._____Date of Onset:_____

Additional concerns you would like addressed:

2._____Date of Onset:_____

3._____Date of Onset:_____

What treatments have you received for these conditions? _____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

Please list any drug or food allergy:_____

_____

Do you have any reason to believe you may be pregnant? Yes___ No___

Past Medical History (circle any that apply):

Cancer	AIDS/HIV	Allergies	Epilepsy
Diabetes	Hepatitis A/B/C	Fibromyalgia	Pacemaker
Heart Disease	Arthritis	Chronic Fatigue Syndrome	Stroke
High Blood Pressure	High Cholesterol	Disc Problems	Kidney Disease
Alcoholism/Addiction	Anxiety/Depression	Asthma/Hay fever/Hives	Ulcer/GERD

Other:_____

Please list any surgeries/hospitalizations and dates_____

_____

What is your most recent blood pressure reading? _____ / _____ When was this reading taken? _____

Childhood Illness (please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Other:_____

Lifestyle:

a. Do you typically eat at least three meals per day? ___Yes ___No If no, how many?_____
b. Exercise Routine: _____
c. How many hours per night do you sleep? _____ Do you Wake Rested? Yes No
d. Occupation: _____Employer:_____ Hours/Week?:____

e. Do you enjoy work? __Yes __No
f. Do you smoke cigarettes? __Yes __No If yes, how long? _____ How Often?_____
g. Do you consume alcohol? __Yes __No If yes, what kind? _____
h. Do you use recreational drugs? ___Yes ___No If yes, what kind?_____
i. Do you drink caffeine? __Yes ___No If yes, what kind?_____ How often?_____
j. How much water do you drink per day? _____
k. Have you experienced any major traumas? __Yes __No If yes, describe?_____

X_____ _____

Signature of Patient or Legal Guardian Date signed

COLORADO MANDATORY DISCLOSURE FOR ACUPUNCTURE

Colorado Law requires all acupuncturists provide the following information to clients on their first visit.

Education, Experience, Degrees, Certificates, Licenses, and Registration:
Meagan Boudreaux, L.Ac has been licensed in the state of Colorado since 2004 in, and passed the National Board Exam (NCCAOM) for acupuncture and oriental medicine. After graduating from Colorado School of Traditional Chinese Medicine with a Master's of Science in Oriental Medicine, Meagan traveled to Harbin, a province in Northern China to continue her studies in acupuncture, gynecology, and Tui Na massage. Meagan is also certified in facial rejuvenation acupuncture and has never had any license, registration, or certification issued by any local, state or national healthcare agency, revoked or suspended.

Cash Fee Schedule:		Insurance Fee schedule:
Initial Acupuncture Treatment (Incl. exam) …..	$125.00	Each insurance company is different.
Follow-up Acupuncture Treatment…….	$75.00	

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statue Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. This office uses only single-use, disposable, factory-sterilized needles. The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have any comments, questions, or concerns, please contact the Acupuncturists Registrations Office, 1560 Broadway, Suite 1350, Denver, CO 80202 (phone: 303.894.2440). The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies.

I, the patient, understand and agree to hold harmless, indemnify and protect against court action the individual acupuncturist/therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Print): _____

X_____ _____
Signature of Patient or Legal Guardian Date signed

CONSENT TO TREATMENT FORM FOR ACUPUNCTURE

It is our practice to provide you, the patient, with the following information regarding your acupuncture treatment:

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (moxibustion) at specific points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects my result. These could include but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that if I receive direct or indirect moxibustion as part of therapy, there is a risk of burning or scarring from its use.

Chinese herbs: I understand that substances from the Oriental Material Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances, but must follow the directions for administration and dosage if I do decide to take them. Although rare, I am aware that certain adverse side effects may result from taking these substances. The most common of these side effects is changes in bowel movement. Should I experience any problems that I associate with these substances, I will suspend taking them and call my practitioner as soon as possible.

Acupressure/Tui-Na/Shiatsu Massage: I understand that I may also be given acupressure/tui-na/shiatsu massage as part of my treatment to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to: bruising, sore muscles or achiness.

Cupping/Gua-sha: I understand that I may also be given cupping/gua-sha as part of my treatment to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from taking these substances. The most common of these side effects is short –term bruising. I understand that I may stop the treatment at any time.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result from this treatment. These could include but are not limited to: pain or discomfort, and the possible aggravation of symptoms existing prior to treatment.

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Oriental medical modalities and/or substances from the Oriental Materia Medica. I understand that I may ask to stop any of the above therapies if they become uncomfortable, and I may ask my practitioner for a more detailed explanation of any of the therapies.

Name of Patient(PLEASE PRINT):_____ Date_____

X_____
Signature of Patient (or Responsible Party if minor)

FINANCIAL POLICY

Please read and initial each statement:

_____**Payment is due at time of service unless arrangements have been made in advance**. You are financially responsible to us for all cash fees, co-payments and any amount your insurance company deems your responsibility such as deductibles and co-insurance, as well as denials for services not covered under your policy. We accept Visa, Discover, MasterCard, American Express, checks and cash. Please note: if paying by check, you agree to pay in full all dishonored checks plus a processing fee.

_____ **Not all insurance plans cover all services**. In the event that your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of statement from our office.

_____ We file insurance claims with your individual insurance company as a courtesy to you. However, your insurance policy is a contract between you and your insurance company. As the patient, **you are ultimately responsible to us for payment for services rendered.**

_____We verify your insurance benefits as a courtesy to you. **Verification of benefits does not guarantee payment** by your insurance company as there may be other restrictions included in your policy not given to our staff in the verbal or written benefit description. **It is your responsibility to understand your benefits** and what is covered under your plan.

_____ It is your responsibility to **inform us of any changes in your insurance coverage**. Timely filing deadlines do exist and you will be financially responsible for any charges that are incurred as a result.

Only after exhausting our internal attempts for payment, we will send a delinquent account to our collection agency or small claims court. Any collection fees, court costs, or reasonable attorney fees are the responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. You will be required to pay your account in full before scheduling another appointment if your account is in collections.

CANCELLATION/MISSED APPOINTMENT POLICY

In order to better serve our patients and ensure that our providers are compensated for their time, we require at least 24-hour advanced notice if you will be unable to attend your appointment.

A cancellation that is less than 24 hours prior to your scheduled appointment will be considered a missed appointment and you will be responsible for the full price of the appointment. Late cancelation/missed appointment charges cannot be submitted to insurance or injury claims and will be charged at our cash fee rates listed below.

30 minute massage therapy session.	$40.00
60 minute massage therapy session.	$75.00
Acupuncture appointment.	$75.00
Chiropractic appointment.	$70.00

I have read and understand the above FINANCIAL POLICY, and CANCELLATION POLICY and I agree to be bound by its terms.

Name of Patient(PLEASE PRINT):_____ Date_____

X_____

Signature of Patient (or Responsible Party if minor)

CONSENT TO TREATMENT

I hereby give permission to the doctor to release any information requested by my insurance company, physicians, or other health care providers acquired in the course of my examination and treatment. I also give consent to submit request(s) for any information from my insurance company, physicians, or other health care providers. I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services. I hereby give permission to the doctor and/or therapist to administer treatment and perform such general procedures as he/she may deem necessary in the diagnosis and/or treatment of my condition. I fully understand that this consent will remain in effect until revoked in writing. I have read and I do understand and agree to the above statements.

NOTICE OF PRIVACY POLICY

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 have received, read and understand your NOTICE OF PRIVACY PRACTICES wherein a more detailed description of the uses, examples of and disclosures of my personal health information ("PHI") exists. 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 office at any time if I wish to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

Name of Patient(PLEASE PRINT):_____ Date_____

X_____

Signature of Patient (or Responsible Party if minor)

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