Brunswick Integrative Health
Holly J. Brown, DAOM, LAc & Molly Maguire, Dipl. OM, LAc
311 Maine Street, Suite 11 • Brunswick, ME 04011 • 207-809-2282

Name:_____**Date of Birth:**_____
Phone (home #):_____(cell #):_____
Address:_____City_____State____ Zip Code_____
E-mail:_____
Occupation:_____Marital Status:_____
Emergency Notification : _____
Main Concerns:_____ Onset:_____

Past Medical History (include dates):
Surgeries:_____
Significant Traumas (auto accidents, falls,etc.):_____
Allergies (food, drug, chemical): _____
Pregnancies (births, miscarriages, abortions, etc.): _____
Cancer_____Diabetes_____Heart Disease_____High Blood Pressure_____
Hepatitis_____Rheumatic Fever_____Seizures_____Thyroid Disease_____
Venereal Disease_____HIV/AIDS_____Candida_____Other_____
Exposure to environmental contaminants:_____

Habits:
Cigarettes__ Coffee__ Tea__ Cola__ Alcohol__ Drugs__ Other_____

Family Medical History:
Cancer_____Diabetes_____High Blood Pressure_____Heart Disease_____
Stroke_____Seizures_____Asthma_____Allergies_____Alcoholism____ Other
_____
Physicians:_____
_____

Were you referred to us? Yes | No
If so, by whom? _____
May we contact them to express our gratitude? Yes | No
And if so, may we refer to you by name? Yes | No

_____
(Printed Name & Signature – Patient or Representative)
Relationship to patient (if other than patient):_____**Date:**_____

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Prescription Information Form :

Name_____

In order to best treat your condition, we require your current use of prescription medications. Please accurately list all of your medications, the dosages, how long you have been taking them, and the reason you're taking them:

Medication:	Dosage:	Length Of Time:	Reason:

Are there any other medications/drugs used in the past that should be brought to our attention?

_____

_____

_____

Medication Adjustments:
With acupuncture and herbal therapy, dosages of medications may need to be adjusted. I understand that any changes in the medication and/or dosages will be done gradually and under the care of all of my physicians.

_____

(Printed Name & Signature – Patient or Representative)

Relationship to patient (if other than patient):_____Date:_____

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OFFICE POLICIES
Welcome to the offices of Dr. Holly J. Brown, DAOM, LAc and Molly Maguire, LAc. We are honored that you have chosen us to support you in the care of your health. Please do not hesitate to ask any questions. We are grateful for the opportunity to serve you and hope to exceed your expectations.

FEES The fees charged in this office are comparable to those charged by other healthcare providers in this area with similar qualifications. Please ask to see our fee schedule. We accept cash, credit cards, and personal checks. Please note that there is a $35.00 charge for checks returned due to insufficient funds.

INSURANCE COVERAGE Many insurance policies cover Acupuncture and Integrative Medicine, but we do not claim that yours does. Policies differ greatly in terms of deductible and percentage of coverage. We offer complimentary benefit verification and will submit your claim form for you, provided you sign the financial agreement below.

RELEASE OF INFORMATION Your insurance company may require medical reports to document our treatment and progress. Your initials below authorize the release of medical information necessary to process your claim.

CANCELLATIONS As a courtesy to our office and other patients, we ask that you please notify the office at least 24 hours in advance if you need to cancel or reschedule your appointment. You will be charged a $90.00 fee for any missed appointment or cancellation giving less than 24 hours notice for any non-emergency situations.

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS
I am receiving or am about to receive health care services in this office. I understand that I am responsible for paying all non-insurance related fees when services are rendered, including herbs, etc. If I choose to use my insurance, I understand that I will be responsible for all “non covered” services and/or co-insurances/co-pays associated with my appointment. I understand that if I give incomplete or inaccurate insurance information, I may be responsible for the balance if the office is unable to collect in full from my insurance. In addition, I authorize insurance payment of medical benefits to Holly J. Brown.

By signing below, I agree to comply with the office policies stated above, which I have read and understood. I also authorize the use of this signature on all insurance submissions.

_____
(Printed Name & Signature – Patient or Representative)
Relationship to patient (if other than patient):_____**Date:**_____

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Informed Consent for Acupuncture Treatment

I hereby agree and consent to the performance of acupuncture and/or other Oriental Medicine procedures. I understand that such procedures may include, but are not limited to, acupuncture, moxibustion, cupping, and gua-sha (dermal friction technique), infrared heat lamp, breathing techniques, exercise therapy, Tui-Na (Chinese massage), diagnostic evaluation, Chinese or western herbal medicine, and nutritional counseling.

Acupuncture: Technique utilizing fine, sterile, one-time use needles inserted at specific points in the body to correct various ailments.

Moxibustion: Application of indirect heat by burning a stick of compressed Folium Artemisiae vulgaris, commonly known as Mugwort, over acupuncture points.

Cupping: Utilizes round suction cups over a large muscular area (such as the back) to enhance blood circulation to the designated area.

Tui-na: Form of Chinese body treatment (massage) used in facilitating healing and pain management. Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment.

I have been informed that in all acupuncture treatments only sterile, disposable needles are used, according to the Clean Needle Technique protocol, to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the acupuncturist if I experience any symptoms or problems. I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed.

I understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I am relying on the TCM practitioner to exercise judgment during the course of my treatment, trusting that, based upon facts then known, this treatment plan is appropriate and in my best interests. I understand that acupuncture and other Oriental Medicine procedures are not substitutes for treatment by my medical doctor. Also, at any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan.

I state that I **do not** have the following conditions: Pregnancy, bleeding disorders, pacemaker, local infections; or am not currently taking anticoagulants. If I have any of the above conditions, I will advise the office staff or provider.

By signing below I, hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_____
(Printed Name & Signature – Patient or Representative)
Relationship to patient (if other than patient):_____**Date:**_____

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HIPAA NOTICE OF PRIVACY PRACTICES
As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for equipment or supplies coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our organization. These activities include, but are not limited to,

quality assessment activities, employee review activities, accreditation activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to accrediting agencies as part of an accreditation survey. We may also call you by name while you are at our facility.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Criminal Activity, Inmates, Military Activity, National Security, and Workers' Compensation.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object, unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of

treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for

notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

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We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions concerning or objections to this form, please ask to speak to us in person or by phone at **207-809-2282**.

Associated companies with whom we may do business, such as an answering service or delivery service, are given only enough information to provide the necessary service to you. No medical information is provided.

We welcome your comments: Please feel free to call us if you have any questions about how we protect your privacy. Our goal is always to provide you with the highest quality services.

_____
(Printed Name & Signature – Patient or Representative)
Relationship to patient (if other than patient):_____**Date:**_____

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HIPAA email consent :

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is encrypted.
- Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet.
- In addition, once the email is received by you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Please check one:

❑ **OPTION 1 – ALLOW UNENCRYPTED EMAIL**

-I understand the risks of unencrypted email and do hereby give permission to the Holly J. Brown Office to send me personal health information via unencrypted email.

._____.
Date Printed name Signature (parent or guardian if patient is a minor)

Please print email address_____.

❑ **OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL**

-I do not wish to receive personal health information via email.

._____.
Date Printed name Signature (parent or guardian if patient is a minor)

Name:_____ DOB:_____

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I hereby authorize:_____
to release a copy of my medical records, including x-rays and reports to:

The Office of Holly J. Brown, LAc, DAOM

331 Maine St. Suite 11 Brunswick, ME 04011
Fax: 207-809-2146
Phone: 207-809-2282

℅ Holland Chiropractic 36 School St. Bath, ME 04530
Fax : 207-443-1244
Phone:207-809-2284

Please include the records for the following family members:
Name: DOB: Relationship: _____
_____
_____
_____

_____
(Printed Name & Signature – Patient or Representative)
Relationship to patient (if other than patient):_____Date:_____

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Waiver to Collect for Non-Covered Services

Patient's name:_____Date:_____

I understand that I am responsible for all costs associated with services which are not covered by my healthcare plan. These costs may include office visits, report of findings, herbs purchased, co-payments, deductibles or co-insurance amounts, cupping, manual therapies and herbal consultations.

By signing this waiver, I agree to the recommended services and any uncovered fees associated with the service or procedure provided.

It is my responsibility to provide any required referrals. If I fail to do so, I will be responsible for all charges that are not covered.

Signature of Patient:_____
OR
Signature of Parent/Legal Guardian if patient is a minor:_____
Printed Name of Parent/Legal Guardian if patient is a minor:_____