Holly J. Brown, L.Ac, DAOM
Molly Maguire, L.Ac
36 School Street • Bath, ME • 04530 • 207-809-2284
331 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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Name:_____ **DOB:**_____

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

Holly J. Brown, LAc, DAOM

331 Maine St. Suite 11 Brunswick, ME 04011
Fax: 207-809-7046
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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Notice of Privacy

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This consent was signed by: Date:_____

_____

(Printed Name & Signature – Patient or Representative)

Relationship to patient (if other than patient):_____

Witness:_____

(Signature & Printed Name – Practice Representative)

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Payment Methods Accepted: Cash, Check, Visa, Mastercard, and Discover are accepted.

Returned Checks: Each returned check will incur a fee of $35.

Cancellations or Missed Appointments: We require a notice of 24 hours if you need to cancel an appointment, or you will be billed directly at the rate of $90 for your missed appointment.

If Your Health Insurance Policy Covers Acupuncture: In-Network: We will file to your insurance company. Out-of-Network: As a courtesy to you, we will file to your insurance company for you for your reimbursement.
If you have a Health Savings Account: Acupuncture treatment is allowable under all HSA's. You will need to check with your individual HSA to find out if herbal medicine prescribed by a health professional is an allowable expense.
If You are a Medicare Patient: At this time, Medicare does not cover acupuncture services.

Discount for Paying in Full at the Time of Service: Because paying-in-full at the time of service frees our office from the administrative costs required in insurance billing, we have adjusted our "usual & customary" fees. Your superbill/receipt form will show exam and treatment procedures that occurred during your visit. Depending on the nature of your treatment that day, certain procedure codes and/or exam codes may be modified to $0.00 and you will only be responsible for certain other fees, as follows:

New Patient: CPT 99203 (60-90 mins):	**$205 - $295**
Acupuncture Follow-up: CPT 97810,97811 (45-60 mins):	**$90 - $125** (see discount program below)
Acupuncture with E-stim: CPT 97813, 97814:	**$90 - $140**
Extended/Review of Findings: CPT 99213:	**$140**
In person/phone consult (for active patients only): CPT 99371:	**$35 per 15 minute increment**
Herbal Formulas / Supplements:	**varies**

Acupuncture is Tax Deductible: Keep track of your receipts or request a ledger at the end of the year. The costs of acupuncture treatments and "prescribed herbs and supplements by an acupuncturist or physician for treatment of a specific condition diagnosed by an acupuncturist or medical practitioner" are deductible medical expenses.**(http://www.irs.gov/pub/irs-pdf/p502.pdf)**

Explanation of Insurance Coverage: Many insurance policies do cover acupuncture care, but this office makes no representation that yours does. Insurance policies vary greatly in terms of deductible and percentage of coverage for acupuncture care. Because of the variance from one policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance our usual and customary fees in a timely manner.

I have read and agree to the above Financial Policy.

_____

(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), 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 or fainting, 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 currently taking anticoagulants. If I have any of the above conditions, I have listed them here:_____

_____

By voluntarily 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.

Date:_____

_____

(Printed Name & Signature – Patient or Representative)

Relationship to patient (if other than patient):_____

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HIPAA email consent :

VERY IMPORTANT! PLEASE READ!

- 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)

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Informed Consent
Insurance Verification & Billing

I hereby authorize Holly J. Brown's office of Acupuncture and Oriental Medicine, acting as service agent for Holly J. Brown DAOM, L.Ac, to contact my insurance carrier (shown below) in order to determine eligibility for services.

I understand that my insurance may be billed for services rendered by Holly J. Brown or licensed staff providing treatments. I agree that if my insurance carrier issues a check in my name for reimbursement for services rendered, I will within five days of receipt of this check make payment in the amount of said check to Holly J. Brown.

The following also applies to the use of my insurance to cover the cost of services rendered:

Authorization To Release Medical Information For Billing
- I hereby authorize the release of any information regarding services by the Physician/Facility to process insurance claims and allow a photocopy of my signature to file insurance claims.

Assignment Of Insurance Benefit
- I hereby authorize irrevocably assignment of payment for my benefits due me for the services rendered by the practitioner and the facility made directly to the physician and/or the facility.

Financial Responsibility
- I understand that if I am utilizing an "out of network" provider for the services rendered by the facility, regardless of my insurance benefits, that I alone am fully financially responsible for the fees for the services rendered. I agree to collect charges which will be added to my past due accounts.

Authorization For The Release Of Medical Information For Treatment
- I hereby authorize the above physician and facility to obtain and release copies of my medical records and information regarding my medical history, mental or physical conditions for the purpose of further treatment and evaluation.

Patient Name:

.

Signature & Date:

.

Insurance Name: Insured Birth Date:

.

Insurance Policy #:

.

Insurance Type: ( )PPO ( )POS ( )HMO ( )MEDICARE ( )MEDICAL ( )Other Primary

Insurance: Any Secondary Insurance (if so, please state): Name: Policy#

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