

WELCOME !

Thank you for your interest in working with me to discover what acupuncture can do for you. I look forward to supporting you in achieving greater wellness and healing. This letter provides you with information you need for your first visit. It also includes some forms to fill out which will give me some background information about you.

Your first appointment will last about 2 hours and will consist of a health history and physical exam. During this time my main focus is to get to know you and to understand your health concerns so that I can focus treatment on your needs. Subsequent treatments will last about between 1 and 1 ½ hours. To assist me in your treatment, please do not wear perfume/cologne to your visits as odor affects my diagnosis. Also, please do not drink alcohol before or after your appointments as this will significantly affect the outcome of your treatment.

The cost of your acupuncture treatments:

- *Initial Visit* \$85
- *Subsequent Treatments* \$80

Payment is due when services are rendered.

If you need to cancel an appointment, please call at least 24 hours in advance. Non-emergency cancellation (less than 24 hours) are subject to a \$50 late cancellation fee.

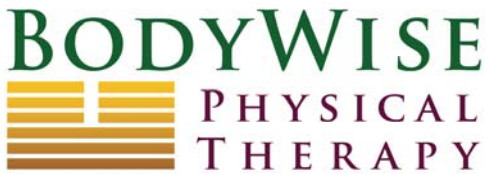
Health insurance is an arrangement between you and your insurance company and as each company's policy differs you should contact them to determine if you are covered for acupuncture. It is a policy of this clinic that payment is made at the time of treatment and that patients file for reimbursement with their insurance company. Please let me know if you need a receipt to submit to your insurance company.

I generally request that you schedule 5 weekly appointments initially. Many of the early treatments are cumulative in nature and most effective when reinforced on a regular schedule. At the end of this time we will know how acupuncture has served you and we can determine how further treatments should proceed.

My philosophy is to use acupuncture to assist you in seeing new possibilities for healing and wellness, and for enjoying life more and being at peace within yourself and the world around you. Acupuncture stimulates the immune system and increases awareness, which allows one to flourish and live life more fully.

Thank you for joining me in a journey toward more balanced living. If you have any questions please feel free to call me.

*In Wellness,
Arianna Z. Berkowitz, MPT, L.Ac.*



9881 Broken Land Parkway
Woodmere I, Suite 103
Columbia, MD 21046
TEL 240.841.2639
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www.BWtherapy.com

Patient Information

Last Name: _____ First Name: _____ MI _____

Gender: M F Date of Birth: _____ Marital Status: Single Married Divorced

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SSN: _____ - _____ - _____

Emergency Contact Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employment Information Full- Time Part-Time Self-Employed Not Employed

Occupation / Title: _____

Name of Employer: _____

Address: _____
Street City State Zip

Physician Information

Primary Care Doctor: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Primary Insurance

Insurance: _____ ID _____ Group # _____

Effective Date (Medicare) _____

Name of Cardholder: _____ Relationship to Patient: _____

Date of birth of cardholder: _____ Co-payment: _____

Secondary Insurance

Insurance: _____ ID _____ Group # _____

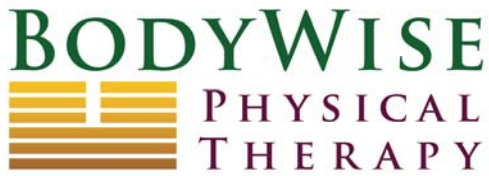
Effective Date (Medicare) _____

Name of Cardholder: _____ Relationship to Patient: _____

Date of birth of cardholder: _____ Co-payment _____

Patient Signature _____

Date: _____



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MEDICAL HISTORY

Name: _____

The reason(s) you are here: _____

Date of Injury: _____ Is this a work injury? _____ Is this a result of a motor vehicle accident? _____

Is the injury/accident the fault of another party? _____

Since the onset of this injury /condition, have you received any of the following? (please circle all that apply):

- X-Ray MRI CT Scan Injections Massage Therapy Chiropractic Bone Scan
Nerve Blocks Physical Therapy Acupuncture Other _____

Do you have a history of any of the following? (please circle all that apply):

- Heart disease Cancer Diabetes Shortness of Breath Allergies Metal Implants
Pace maker Hypoglycemia High Blood Pressure Stroke Osteoporosis Chest Pain
Other _____

If you have ever been hospitalized for a serious medical illness or operation, please list the most recent ones below (do not include normal pregnancies).

Table with 2 columns: Year, Operation / Illness

Medicines:

What prescription drugs are you taking? For what condition?

What over-the-counter medications, herbs, or supplements are you currently taking? For what condition?

Personal Lifestyle Habits: For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs) _____
Coffee / Tea (cups) _____
Alcohol (drinks per week) _____
Illicit Drugs: _____

For the following, please put a **“C”** if the condition is current or a **“P”** if you had it in the past.

General

- Insomnia
- Dreams / nightmares
- Fatigue
- Poor memory
- Strong desire for cold drinks
- Strong desire for hot drinks
- Significant weight loss/gain
- Cold hands & feet
- Chills
- Fever

Head & Neck

- Headaches
- Migraines
- Stiff Neck
- Dizziness
- Fainting
- Swollen glands

Ears

- Ringing
- Hearing loss
- Hearing aides
- Infections
- Earache
- Vertigo

Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Dry eyes
- Double vision
- Glaucoma
- Cataracts

Nose, Throat, & Mouth

- Sinus infection
- Hay fever / allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleeds
- Dry nose

- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ pain/dysfunction
- Facial pain
- Gum problems
- Dry mouth

Skin

- Hives
- Rashes
- Eczema
- Psoriasis
- Excess sweating
- Night sweating
- Dry skin
- Easily bruised
- Changes in moles, lumps
- Itching

Respiratory

- Difficulty breathing
- Difficulty breathing, reclined
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia

Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Swollen ankles
- Phlebitis
- Anemia
- Heart attack
- Stroke

Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid reflux
- Bloating
- Bad breath
- Laxative use
- Bloody stool
- Hemorrhoids

Musculoskeletal

- Joint pain/ arthritis
- Sore muscles
- Weak muscles
- Difficulty walking
- Neck/shoulder pain
- Upper back pain
- Lower back pain
- Rib pain
- Other _____

Urinary

- Pain with urination
- Frequent urination
- Urgency
- Blood in urine
- Incontinence/ leaking
- Incomplete urination
- Bedwetting
- Wake to urinate
- Kidney stones
- Bladder / urinary infections

Neurological

- Seizures
- Tremors
- Numbness or tingling
- Paralysis
- Poor coordination
- Loss of balance
- Other _____

Mental / Emotional

- Depression
- Mood swings
- Irritability
- Difficulty relaxing
- Loneliness
- Sensitive
- Shy
- Cry often
- Worry often
- Compulsive behaviors
- Difficulty concentrating
- Hopeless outlook
- Suicidal thoughts
- Lose temper
- Frustration

Male Genital / Sexual

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain / itching of genitalia
- Lumps in testicles
- Increased libido
- Low libido

Gynecology / Female Sexual

- Pregnant
- # of pregnancies
- Miscarriage
- Abortion
- Menopause
- Hormone Replacement
- Irregular Periods
- Menstrual Cramps
- Breast tenderness
- Breast lumps, cysts
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/ itching
- Excessive vaginal discharge
- Yeast infections
- Uterine fibroids
- Ovarian cysts
- Endometriosis
- PMS
- Increased libido
- Low libido

Signature _____

Date _____

CONSENT TO SERVICES

Acupuncture

Services to be Provided

I understand that acupuncture serves individuals with a wide range of complaints including both acute and chronic health conditions. I understand that I may be treated with the insertion of needles, cupping, gua sha, and/or moxabustion.

Risks/Possible Side Effects/Healing Response

I understand that the above procedures may result in certain side effects including, but not limited to: local bruising, slight bleeding, fainting, temporary pain and discomfort, temporary discoloration of the skin, and temporary aggravation of symptoms existing prior to treatment.

Manual Therapy & Bodywork

Services to be Provided

I understand that the bodywork I receive is for the basic purpose of relaxation and the relief of muscular tension and pain.

Risks/Possible Side Effects/Healing Response

I understand that I may experience some pain or discomfort from manual therapy/ bodywork. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that he/she can adjust the pressure/technique to my level of comfort. I will not hold the practitioner responsible for any discomfort or reaction I may experience.

I have read and understand this form and acknowledge that the purposes, goals, techniques, procedures, limitations, potential risks and benefits of the service(s) to be provided have been explained to me. Further, I have had the opportunity to discuss my concerns and questions with my practitioner regarding the proposed services and other pertinent information, and have received satisfactory responses and answers to my concerns and questions. I understand that I am free to discontinue service(s) at any time.

Signature of client

Date

Printed name of client



Effective Date: April 1, 2009

NOTICE OF PRIVACY & DISCLOSURE PRACTICES

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. The law requires that we maintain the privacy of your medical information. We are required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. We reserve the right to make changes to our practices and this notice, and we promise to make a good faith effort to notify you of any changes.

Your health information will be routinely used for treatment, consultation, payment and quality monitoring, and your consent or the opportunity to object or agree is not required in these instances. Your medical information may be shared with others involved in your care or providing consultation about your treatment. We may use and disclose your medical information to your insurance plan or third-party payer with accompanying documentation that identifies you, your diagnosis and/or practitioner's impressions and procedures performed. Your information may be reviewed for risk management or quality improvement purposes.

We may, as part of routine practice, use and disclose some or all of your health information to family members, a close personal friend identified by you, or other personal representative in order to help with your health care or assist with the payment of your health care. You have the right to request restrictions on these uses. For any other use or disclosure, we will first obtain your written authorization before disclosing your personal health information. You can revoke an authorization at any time by notifying our office in writing.

Additional disclosures are required by law and do not require your consent. These include: the disclosure of health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements; the release of health information to worker's compensation to the extent authorized by law; the disclosure of health information to public health and or legal authorities to avert a serious threat to public health or safety, to report communicable disease, injury, or disability or to comply with mandated reporting requirements for tracking of birth and morbidity; and the disclosure of your health information as required under state and federal law to the appropriate law enforcement officials, public health authorities, and/or attorneys: (1) in response to a valid subpoena, (2) in the event of suspected unlawful conduct of a practitioner or violations of professional standards; (3) when a patient is the suspected victim of abuse, neglect or domestic violence.

Your health record is the property of BodyWise Physical Therapy & Acupuncture, LLC, but the content is about you, and therefore belongs to you. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information list in this notice. If we are unable to accommodate your request, we will charge you a reasonable cost-based fee for expenses such as copies, postage, staff time and other expenses as applicable. You have the right to receive a list of instances in which we or our business associate disclosed your health information for purposes other than treatment, payment, health care operation and certain other activities for the last six (6) years, but not before the effective date of this notice. If you request this accounting more than one in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. You have the right to request restrictions on the uses and disclosures of your health record. Your request must be made in writing and must specify your additional restriction. You have the right to receive confidential communications and to request such communication by alternate means or to alternate locations should we need to contact you. Your request must be made in writing and must specify the alternative means necessary. You will be notified if we are unable to accommodate your request. You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. You will be notified if we are unable to accommodate any of the above requests.

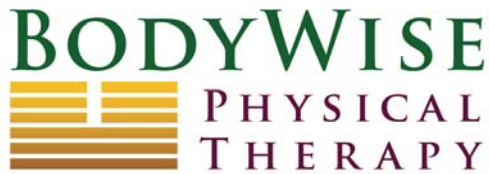
To receive additional information or report a problem, you may contact our clinic administrator at 240-841-2639. If you believe your privacy rights have been violated, you have the right to file a complaint with us by contacting our clinic administrator and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office. Office for Civil Rights Hotline: 1-800-368-1019

I hereby acknowledge my receipt and understanding of the **Notice of Privacy & Disclosure Practices** and agree to the policies and practices set forth herein.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative



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CANCELLATION & MISSED APPOINTMENT POLICY

- Please be advised that we require 24 hrs. notice for appointment cancellations.
- Our fee for a late cancellation or failure to show for an appointment is \$50.00.

LATENESS POLICY

- Please be advised that if you are more than 10 minutes late for your scheduled appointment, your acupuncture session may be shortened accordingly.
- You will still be charged the full amount for your treatment.
- If you are more than 30 minutes late, we may reschedule your appointment and charge you the \$50.00 late cancellation fee for that appointment.

We thank you for your cooperation and integrity.

I have read and understand the above stated policies, and I will honor them accordingly.

Signature

Date