

9881 Broken Land Parkway
Woodmere I, Suite 103
Columbia, MD 21046
TEL 240.841.2639
FAX 240.841.2644
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 # _____

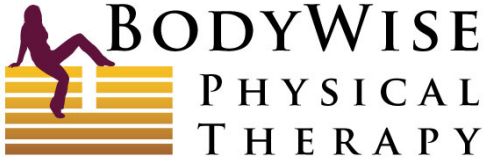
Effective Date (Medicare) _____

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 had any operations or ever been hospitalized for a serious medical illness, please list below (do not include normal pregnancies).

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

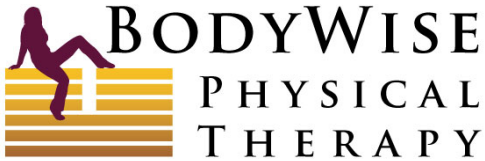
- ___ Impotence
- ___ Premature ejaculation
- ___ Nocturnal emission
- ___ Pain / itching of genitalia
- ___ Lumps in testicles
- ___ Increased libido
- ___ Low libido

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 _____



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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 and/or with the application of heat to the skin.

Risks/Possible Side Effects/Healing Response

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

Manual Therapy/ Therapeutic Massage/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.

Risks/Possible Side Effects/Healing Response

I understand that I may experience some pain or discomfort from massage/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.

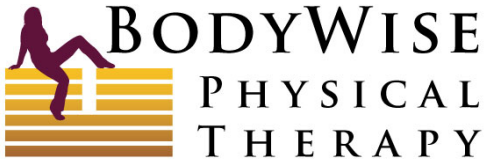
To receive additional information or report a problem, you may contact our clinic administrator at 240-841-2639. If you believe your privacy rights have been violated, you have the right to file a complaint with us by contacting our clinic administrator and/or with the U.S. Secretary of Health and Human 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