Wholistic Family Healthcare
Simeon L. Pollock, L.Ac., L.M.T.
The Castle at Forest Glen
10 Post Office Road
Suite 210
Silver Spring, MD. 20910

Acupuncture, Chinese Herbal Medicine and Massage Therapy
Client Intake/Registration Form, HIPPA and Waiver of Liability

Patient Registration **(PLEASE PRINT CLEARLY!)**

Patient's Name:_____ SS #: _____
First Name MI Last Name

Date of Birth:_____ __Male __ Female __Single __Married __Widowed __ Divorced __ Separated

Street Address :_____

City/State/Zip Code:_____ Home Phone w/Area Code:_____

Cell Phone w/Area Code:_____ Fax w/Area Code:_____

e-mail Address:_____ Can this be used for communicating with you? Yes__ No__

Spouse's Name:_____ SS #:_____

Spouse's Employer:_____ Spouse's Work Phone #:_____

Patient's Employer:_____ Work Phone w/Area Code:_____

Responsible Party:_____ Relationship: __Self __Spouse __Parent __Other:_____

If patient is a Minor, are parents __Married __Divorced Custodial Parent:_____

Custodial Parent's Home Phone w/Area Code:_____ Work Phone w/Area Code:_____

In case of emergency, contact (not living with you):_____

Phone Number w/Area Code:_____ Relationship to Patient:_____

Is this work-related? __Yes __No If yes, date of injury?_____Claim #:_____

Is this auto accident related? __Yes __No If yes, date of injury? _____ Claims#_____

Insurance Company to be billed_____

Adjuster's Name & Phone #_____

Attorney's Name & Phone #_____

_____

Referring Physician's Name & Phone Number:_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company # 1:_____ Phone Number:_____

>>Primary Insured's Name:_____ >>Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

Address:_____

Insurance Company # 2:_____ Phone Number:_____

>>Primary Insured's Name:_____ >>Date of Birth:_____

Policy #:_____ Group #:_____ Relationship:_____

Address:_____

- I hereby authorize the payment of medical benefits to Simeon Pollock, L.Ac., L.M.T. for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I permit a copy of this authorization to be used in place of the original.
- I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
- I hereby authorize Simeon Pollock, L.Ac., L.M.T. to release any medical information necessary to complete and process my insurance claims.

>>_____ _____
>>Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date

I authorize Simeon Pollock, L.Ac., L.M.T.. to treat me and use my personal health information for healthcare operations.

>>_____ _____
>>Patient's Signature (OR Parent if patient is a Minor) Date

Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of Simeon Pollock, L.Ac., L.M.T.. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of Simeon Pollock, L.Ac., L.M.T., accurate billing information at the time of check in and to notify the provider of any changes in this information.

- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the provider also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.

- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.

- I understand that the provider will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.

- I have received a copy of the Notice of Privacy Practices as required by HIPAA from Simeon Pollock, L.Ac., L.M.T. and understand my rights with regard to my personal health information disclosure.

My signature below confirms that I have read and understand these billing policies, privacy practices and my financial obligation as pertains to the health care provider Simeon Pollock, L.Ac., L.M.T..

_____ _____

Patient's Signature Date

_____

Legal Guardian to Patient (if patient is minor or incapable of signing)

Major complaints (reason for seeking treatment):_____
_____.

Medical History:
Are you currently under a Doctor's care? Y N For what condition?_____
_____
_____.
Please list any current medications, herbal remedies, vitamins, supplements (prescribed or over the counter):_____
_____
_____.

Please check all that apply:

_Arthritis
_Bursitis
_Fibromyalgia
_Lymes Disease
_TMJ Disorder
_Headaches
_Migraines
_Neck/Shoulder Pain
_Osteoporosis
_Current Pregnancy
_Numbness or Tingling
_Muscle Weakness
_Radiating Pain
_Diabetes
_Hernia
_Sprain/Strain
_Recent Broken Bone
_Surgery
_Skin Disorder
_Respiratory Ailments
_High/Low Blood Pressure
_Fainting
_Heart Disease
_Varicose Veins
_Epilepsy
_Seizures
_Insomnia
_Digestive Disorders
_Liver Disease
_Cancer
_Recent or Current Infection
_Sinus Congestion
_Stress
_Fatigue
_Cardiovascular Disease
_ Trauma
_Other

Please list any additional conditions & all previous traumas here:_____
_____
_____.

Do you smoke? __Cigarettes __Cigars __Pipe

For how many years?_____ How many per day?_____

Do you regularly drink alcoholic beverages?_____ What type?_____
How often?_____

Do you drink coffee?____ tea____ How many cups per day?_____

Have you ever experienced?:

Fainting sometimes often never

Convulsions sometimes often never

Spells of dizziness sometimes often never

Double vision sometimes often never

Weakness of the arm or leg sometimes often never

Ringing in the ears, one or both sometimes often never

Nose bleeds other than from trauma sometimes often never

Loss of balance sometimes often never

Hoarseness sometimes often never

Headaches sometimes often never

Where in the head and how often _____

Female Gynecology

Age at onset of menstruation _____

Number of days of menstrual period _____

Number of days between menstrual periods _____

How many children born alive? _____

How many stillbirths? _____

How many miscarriages? _____

How many abortions? _____

Do you have a regular Pap test? Yes No

Date of last test _____

Do you regularly do self breast examinations? Yes No

If you are over 40 years of age do you get regular mammograms? Yes No

Date of last exam _____

Are you now or have you ever taken birth control pills? Yes No

Onset of menopause - age (if applicable)_____.

If you are post-menopausal are you on or ever been on hormone replacement therapy (HRT)? Yes No

I, _____, understand that the Acupuncture/Massage Therapy

(Print Your Name Above)

given here is for the purpose of stress reduction, relief from muscular tension or spasm, or for increasing circulation or energy flow.

I understand that the Acupuncture/Massage Therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the Acupuncturist/Massage therapist prescribes neither medical treatment nor pharmaceuticals, nor performs any spinal manipulations. It has been made very clear to me that this Acupuncture/Massage Therapy is not a substitute for medical examinations and/or diagnosis and that it is recommened that I see a physician for any physical ailments that I might have.

Because an Acupuncturist/Massage Therapist must be aware of any existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Acupuncturist/Massage Therapist updated upon my physical health, and or pharmaceuticals (medicines) or herbal supplements that I am taking. If I am a female, I will inform the Acupuncturist/Massage Therapist as soon as possible that I am or may be pregnant whether I **think/suspect** or know that I am pregnant.

I understand that our time together is valuable and will give at least 24 hours notice in case of cancellation or rescheduling. I agree that I will pay the full fee for appointments that I cancel or reschedule with less than 24 hours notice or for any missed appointments (no show). I agree to pre-pay any appointments that are rescheduled because I gave less than 24 hours notice of cancellation, rescheduling, or not showing up to an appointment. I understand and agree that this provision may be waived solely at the discretion of Simeon Pollock, L.Ac., L.M.T.

X_____ _____

Signature of patient or authorized person Date

_____

Relationship to patient/client/minor

NOTICE OF PRIVACY PRACTICES

Effective Date: June 1, 2008 **Revision Date:**

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

We respect patient confidentiality and only release personal health information about you in accordance with the State and federal law. This notice describes our policies related to the use of the records of your care generated by Simeon Pollock, L.Ac., L.M.T..

Privacy Contact. If you have any questions about this policy or your rights contact the Privacy Officer at 301-495-0303.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

In order to effectively provide you care, there are times when we will need to share your personal health information with others beyond . This includes for:

Treatment. With your permission we may use or disclose personal health information about you to provide, coordinate, or manage your care or any related services, including sharing information with others outside that we are consulting with or referring you to.

Payment. Information will be used to obtain payment for the treatment and services provided. This will include contacting your health insurance company for prior approval of planned treatment or for billing purposes.

Healthcare Operations. We may use information about you to coordinate our business activities. This may include setting up your appointments, reviewing your care, training staff.

Information Disclosed Without Your Consent. Under State and federal law, information about you may be disclosed without your consent in the following circumstances:

Emergencies. Sufficient information may be shared to address the immediate emergency you are facing.

Follow Up Appointments/Care. We will be contacting you to remind you of future appointments or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

As Required by Law. This would include situations where we have a subpoena, court order, or are mandated to provide public health information, such as communicable diseases or suspected abuse and neglect such as child abuse, elder abuse, or institutional abuse.

Coroners, Funeral Directors. We may disclose personal health information to a coroner or personal health examiner and funeral directors for the purposes of carrying out their duties.

Governmental Requirements. We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations inspections and licensure. There also might be a need to share information with the Food and Drug Administration related to adverse events or product defects. We are also required to share information, if requested with the Department of Health and Human Services to determine our compliance with federal laws related to health care.

Criminal Activity or Danger to Others. If a crime is committed on our premises or against our personnel we may share information with law enforcement to apprehend the criminal. We also have the right to involve law enforcement and to warn any potential victims when we believe an immediate danger may exist to someone, or if we believe you present a danger to yourself.

PATIENT RIGHTS

You have the following rights under State and federal law:

Copy of Record. You are entitled to inspect the personal health record that Simeon Pollock, L.Ac., L.M.T. has generated about you. We may charge you a reasonable fee for copying and mailing your record.

Release of Records. You may consent in writing to release of your records to others, for any purpose you choose. This could include your attorney, employer, or others who you wish to have knowledge of your care. You may revoke this consent at any time, but only to the extent no action has been taken in reliance on your prior authorization.

Restriction on Record. You may ask us not to use or disclose part of the personal health information. This request must be in writing. Simeon Pollock, L.Ac., L.M.T. is not required to agree to your request if we believe it is in your best interest to permit use and disclosure of the information. The request should be given to the provider of care to review and determine if the request can be granted.

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Contacting You. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable and we are assured it is correct. We have a right to verify that the payment information you are providing is correct. We will provide information to the e-mail address you have provided on your registration form if you have checked that you desire that method of communication.

Amending Record. If you believe that something in your record is incorrect or incomplete, you may request we amend it. To do this contact the provider of care in writing indicating what changes should be made. In certain cases, we may deny your request. If we deny your request for an amendment you have a right to file a statement you disagree with us. We will then file our response and your statement and our response will be added to your record.

Accounting for Disclosures. You may request a listing of any disclosures we have made related to your personal health information, except for information we used for treatment, payment, or health care operations purposes or that we shared with you or your family, or information that you gave us specific consent to release. It also excludes information we were required to release. To receive information regarding disclosure made for a specific time period no longer than six years and after your first treatment date, please submit your request in writing to our Privacy Officer. We will notify you of the cost involved in preparing this list.

Questions and Complaints. If you have any questions, or wish a copy of this Policy or have any complaints you may contact our Privacy Officer in writing at our office for further Information. You also may complain to the Secretary of Health and Human Services if you believe Simeon Pollock, L.Ac., L.M.T. has violated your privacy rights. We will not retaliate against you for filing a complaint.

Changes in Policy. Simeon Pollock, L.Ac., L.M.T. reserves the right to change its Privacy Policy based on the needs of Simeon Pollock, L.Ac., L.M.T.. and changes in state and federal law.