Herb + Ōhm™

New Patient Intake Form

Please take the time to fill out this questionnaire. The information you provide will assist us in formulating a complete health profile for you. All your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets.

Patient Information

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Primary Phone: _____

Email: _____How you found us: _____

Current Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

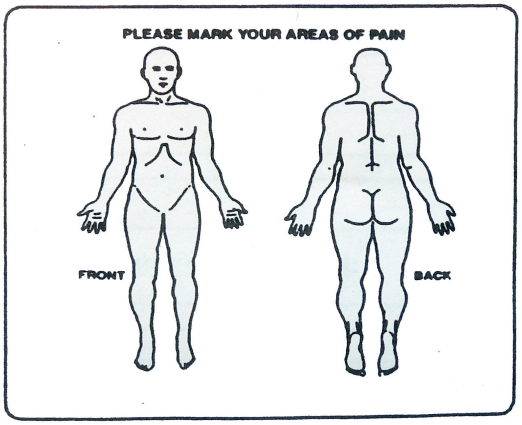
Emergency Contact: _____ Phone: _____

May we contact you by phone or email for appointment reminders, changes, news, and other notices? ☐ Yes ☐ No

Main Complaint

Please briefly describe the main reason you are here and your major symptoms:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



DIAGNOSIS and Recommendations Suggested by Western Physician for Current Concern:

_____

TREATMENTS You Are Currently Receiving by:

1): Medical Doctor_____

2): Chiropractor_____

3): Other_____

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Medical History

Please check any of the following, which have ever affected you and indicate date.

☐ Addiction	☐ Candida	☐ Fungal Infections	☐ Hypotension	☐ Rheumatism
☐ AIDS/HIV	☐ Chronic fatigue	☐ Gallstones	☐ Kidney stones	☐ Autoimmune Dis.
☐ Alcoholism	☐ Dermatitis	☐ Glaucoma	☐ Malaria	☐ Seizures
☐ Anemia	☐ Diabetes	☐ Goiter	☐ Meningitis	☐ Stroke
☐ Arteriosclerosis	☐ Digestive disorders	☐ Gout	☐ Mononucleosis	☐ STD
☐ Arthritis	☐ Eating disorders	☐ Heart Disease	☐ Multiple sclerosis	☐ Thyroid problems
☐ Asthma	☐ Emotional imbalance	☐ Hernia	☐ Nephritis	☐ Tonsillitis
☐ Breast lumps	☐ Emphysema	☐ Hepatitis	☐ Neuralgia	☐ Tuberculosis
☐ Bursitis	☐ Epilepsy	☐ Herpes Zoster	☐ Paralysis	☐ Ulcers
☐ Colitis/bowel disease	☐ Eczema/Psoriasis	☐ High cholesterol	☐ Prostate Problems	☐ Urinary problems
☐ Cancer	☐ Fibromyalgia	☐ Hypertension	☐ Rosacea	☐ Whooping cough

☐ Other: _____

SURGERIES (including plastic surgeries), Hospitalizations, Significant Traumas, or DISEASES You've Had:

_____ **Date:** _____
_____ **Date:** _____
_____ **Date:** _____

MEDICATIONS you are currently taking, including over-the-counter medications:

MEDICATION	DOSAGE	REASON	HOW LONG

SUPPLEMENTS, vitamins, or herbal medicines that you are currently taking:

SUPPLEMENT	DOSAGE	REASON	HOW LONG

ALLERGIES or adverse reactions, especially related to food and/or drugs:

_____
_____

LIFESTYLE: Which of the following is/are part of your lifestyle?

☐ Tobacco Smoking/Use	☐ Special Diet	☐ Exercise
☐ Coffee	☐ Birth Control Pills	☐ Meditation/Relaxation
☐ Alcohol Drinking	☐ Recreational Drugs	☐ Soda

Do you have a pacemaker? ☐ Yes ☐ No Do you bleed for a long time/have bleeding disorder? ☐ Yes ☐ No
Do you currently have any of the following? ☐ Cold/Flu ☐ Infection/Inflammation ☐ Menstruation ☐ Pregnancy/Lactations

The information on this form is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____

Herb + Ōhm™

Summary Notice of Privacy Policies

Herb + Ōhm is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with a Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THE FOLLOWING CAREFULLY.

"Protected health information" is information about you, including demographic information, present or future physical or mental health or condition and related health care services. We are required by law, in most instances, to have your written consent before we use or disclose to others your medical information for the purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may use or release your information without your consent or authorization as may be required or permitted by certain laws.

You have the right to the following:

- Look at and make copies of your protected health information
- Ask us to not release parts of your protected health information
- To be told when we release your protected health information
- Ask us to contact you only in certain ways
- Request us to change parts of your protected health information
- File a complaint if you think your rights have been violated

THIS IS ONLY A SUMMARY

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time. You have the right to obtain a copy of our most recent Notice in effect. Please ask the front desk if you wish to receive a full copy of our Notice of Privacy Practices.

If you have any questions, concerns, or complaints about the Notice or your protected health information, please contact Amy Wolf, L.Ac., DACM at 312-757-1882.

My signature below indicates:

- I have been provided with the Summary Notice of Privacy Practices, and I am aware that I may obtain the most recent copy of the Notice of Privacy Practices in its entirety at the front desk.
- I authorize Herb and Ohm, LLC to use and disclose my health and medical information for the purposes of Treatment, Payment, and Healthcare Operations.

Name (Print) _____ Date _____
Signature _____ Date _____

It patient is under 18 years old, signature of parent or legal guardian:
Signature _____ Date _____

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Consent to Treatment

I, the undersigned, understand that methods of treatment used in this practice may include, but are limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, microneedling and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.
I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in pregnancy and birthing processes.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue, mouth or throat. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based on the facts then known.

I recognize that scheduling an appointment involves the reservation of time specifically for me, and that consequently, a minimum of 24 hours notice is required to reschedule or cancel an appointment. Unless otherwise agreed to in advance, $50 will be charged for sessions missed without such advance notification. I understand that most insurance companies do not reimburse for missed sessions.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment, and healthcare operations received, incurred or carried out at this practice.

Name (Print) _____ Date _____
Signature _____ Date _____

It patient is under 18 years old, signature of parent or legal guardian:
Signature _____ Date _____

Herb + Ōhm Financial Agreement Policy

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills would be handled.

Explanation of Insurance Coverage
Insurance policies vary greatly in terms of coverage for acupuncture, deductible, and percentage of coverage for care. If our services are covered by your insurance policy and we are in network with your insurance company, Herb + Ōhm will submit claims for treatment on your behalf. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductibles in full and any unpaid balances in this office.

Out of Network Providers
For patients who are covered by out of network insurance carriers, upon request, Herb + Ōhm will provide a superbill for you to submit to your insurance company for potential reimbursement. Please note: out of network insurance companies cover a limited amount of diagnoses so there are no guarantees that your insurance company will cover your diagnosis even if you have acupuncture coverage.

FSA (Flexible Spending Accounts) and HSA (Health Savings Accounts)
Herb + Ōhm accepts FSA and HSA credit cards as forms of payment. Herb + Ōhm requires a FSA or HSA credit card to be on file to utilize for check out.

In Network Providers
Herb + Ōhm is an in network provider with BCBS, United Healthcare, and Humana. Herb + Ōhm will verify acupuncture benefits, file claims, facilitate the processing of claims, and await payment on behalf of in network patients only.

Verifying In Network Benefits
If you'd like Herb + Ōhm to verify your benefits, please provide a photo ID, as well as front and back of your insurance card, and date of birth of your plan subscriber (only needed if you are under someone else's plan). This information can be given to us in person or emailed to info@herbandohm.com with a request to verify your benefits.

After we verify your benefits, we will contact you to let you know what is covered. Please allow 5-6 business days to complete this insurance verification process. While we do our very best to provide you with accurate benefit information based on what your insurance company tells us, we also recommend that you confirm these benefits with your insurance company directly prior to starting treatment.

Payment Arrangements for In Network Patients
When using insurance for acupuncture care, your balance due will vary while you meet your policy's annual deductible (if applicable). Once Herb + Ohm submits a claim, your insurance company will apply a portion of the total bill toward your deductible, and this amount is what you will owe per treatment until you meet your deductible.

Based on our office's contracted in-network rates with each provider, the amount due per treatment while you meet your annual deductible may be more or less than our discounted time of service cash rates ($155 for an initial treatment and $105 for follow-

up treatments). We require that you pay your deductible, co-insurance or co-pay at the time of service and prior to receiving any future treatment.

Below are estimates of what you may owe per treatment per carrier as you pay down your deductible.

Estimated Amounts Owed per Treatment per Carrier Until Deductible Met

Insurance Carrier	Initial Treatment	Follow Up Treatment
BCBS	$210	$125
United Healthcare	$133	$90
Humana	$221	$107

Tracking In network Deductibles and Visits Per year
We do our best to track your deductible from the amount you pay in our office. If you are seeing other medical providers and meet your deductible before it is met at our office, please notify us so that we may begin applying your copay or coinsurance in the future. While Herb + Ōhm does its very best to track your number of visits per year and notify you once you are approaching your last covered visit, should you exceed your maximum covered visits per year, you will owe a balance equal to our cash rate for the uncovered visits.

Cancellation Policy/Fees
We require 24 hours notice for cancellation/reschedule of all appointments. If 24 hours notice is not received, we reserve the right to charge a $50.00 cancellation fee.

Assignment of Benefits
This form directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

Release of Information
If your insurance company requires medical reports or records to document your treatment or progress, your signature herein authorizes this office to release the medical information necessary to process your claim.
We hope this answers any questions you might have concerning the financial agreement health insurance policy of this office. Once again, we welcome you to our office, and will be glad to answer any further questions that you may have.

MUST CHECK ONE OPTION
☐ **I have read and agree to the above.**

☐ **I have read, and I opt out of using my insurance for acupuncture treatment.**

Name (Print) _____Date _____

Signature _____Date _____

It patient is under 18 years old, signature of parent or legal guardian:
Signature _____Date _____

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HIPAA E-Mail Release Form

I, _____, want to communicate via e-mail with Herb + Ohm on matters related to my health and/or my medical treatment. I understand that any Confidential Health Information that I send to or receive from the practice is not secure and is sent at my own risk. I will not hold the practice, nor any of its workforce members liable for loss of any confidentiality associated with information transmitted via e-mail. I also understand that it is not the policy of the practice to encrypt any Confidential Health Information I request to be sent via e-mail. Because this information is not encrypted I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

Name (Print) _____Date _____

Signature_____Date_____

It patient is under 18 years old, signature of parent or legal guardian:

Signature_____Date_____

Date of latest version: 8.4.21