Pentz Health Services LLC dba Nevy Health

NEW PATIENT NATUROPATHIC INTAKE FORM

Name:_____ Date: _____/_____/_____

(Last, First)

Mailing Address:_____ _____ _____ _____

City State Zip Code

Phone # (Cell/Home/Work):_____Alternate Phone # (Cell/Home/Work):_____

Cell Phone Provider:_____Email Address:_____

Date of Birth:_____/_____/_____ Gender: □ Male □ Female

SSN #: _____-_____-_____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated / □ Minor

Do you have children? □ Yes □ No If yes, how many?_____

Occupation:_____Employer:_____

Primary Care Doctor? □ None _____Phone#:_____

Women: Any chance you could be pregnant? □ Yes □ No

How did you hear about our clinic?_____

EMERGENCY CONTACT

Full Name:_____Relationship:_____

Primary Phone #:_____Alternate Phone #:_____

INCIDENT INFORMATION

Is this visit due to an accident? □Yes □ No

If yes, what type? □ Auto □ Work □ Other_____

Has the incident been reported? □ Yes □ No

*If yes, to whom?*_____

Payment Method: (Please Circle) **-** Self Pay / Health Insurance

INSURANCE INFORMATION: (N/A □)

Primary Insurance Carrier:_____

Primary Insured/ Policy Holder Name:_____

Relationship to Patient: _____Date of Birth: _____/_____/_____

Policy ID:_____Group #:_____

Telephone:(___)_____-_____Fax:(___)_____-_____

Secondary Insurance: (N/A □) _____

Primary Insured/ Policy Holder Name:_____

Relationship to Patient: _____Date of Birth: _____/_____/_____

Policy ID:_____Group #:_____

Telephone:(___)_____-_____Fax:(___)_____-_____

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This form should be placed in the patient's medical record

Who may we thank for referring you? _____

Reason for Visit: _____ When did this occur: _____

Due to auto/work injury?: _____

How would you describe the pain?: _____

Is pain constant? _____ Does pain travel? _____ Where? _____

What makes it worse? ☐ Sitting ☐ Walking ☐ Bending ☐ Other

What makes it better? ☐ Ice ☐ Heat ☐ Rest ☐ Exercise ☐ Meds

What medications are you currently taking?: _____

Any previous trauma (fall, accident) _____

Any previous surgeries? _____

Any food / drug allergies? _____

Have you seen any other doctors for this condition? _____

Name: _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Pentz Health Services LLC all insurance benefits, if any, payable for services rendered to my minor child or myself. I understand I am financially responsible for all charges whether or not paid by insurance.

Patient Printed Name: _____Date,_____

Patient Signature (or Parent/ Guardian, if minor)_____

if a patient is not yet 18 years old, a parent or *guardian must sign.*

CONSENT TO CARE

As a patient in this office, **I** have the right to know the types of treatment Nevy Health could possibly use and any complication/side-effects to such treatment. In rare cases, underlying physical defects, deformities or pathologies, may render the patient susceptible to injury. I am responsible for informing my doctors about any conditions, diseases. illnesses, etc. Nevy Health will not provide specific treatments if they are aware that such care may be contraindicated. I hereby allow treatment to be rendered to myself by Pentz Health Services LLC dba Nevy Health_

Patient Printed Name: _____Date._____

Patient Signature (or Parent/ Guardian, if minor)_____

If a patient is not yet 18 years old, a parent or guardian must sign.

FINANCIAL POLICY

I understand that I'm responsible for paying all deductibles, co-payments and co-insurance, and any non-covered services at the time of service. If I receive an insurance check, I agree to bring that check to the office within 7 business days. If the account is over 30/60/90 days past due, unpaid balances will be referred to a collection agency for resolution_ I understand I will be assessed any and all collection fees incurred by the clinic. As a courtesy, Pentz Health Services dba Nevy Health will attempt to verify your health insurance benefits and/or necessary authorizations for you. Please be aware. this is only "A **QUOTE** of Benefits/Authorizations." **We cannot guarantee payment or verify that definite eligibility of benefits conveyed to us or to you by your carrier will be accurate or complete. Payment of benefits are subject to all terms, conditions, and exclusions of the member's contract at the time of service.** Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Our office will make every effort to bill your insurance in a timely manner. If your carrier determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service and it will become your responsibility. We recommend you to be familiar with and verify your benefits with your insurance company prior to your services at Pentz Health Services dba Nevy Health. Please be aware, that even then, it is still not a guarantee of benefits or payment. (initials)

MISSED APPOINTMENT POLICY

I understand there will be a $50.00 fee charged for ALL appointments that are not canceled or rescheduled with a minimum of 24 hours advance notice. Please notify us as soon as possible to cancel an appointment.

_____ (initials)

APPOINTMENT REMINDER/ TEST REMINDER POLICY

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, texts, or health information to me including test results as an extension of my care in this office

_____ (initials)

ACKNOWLEDGMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Pentz Health Services LLC dba Nevy Health's Notice of Privacy Practices.
Patient Printed Name:_____Date:_____
Patient Signature (or Parent/ Guardian, if minor)_____
If a patient is not yet 18 years old, a parent or guardian must sign.

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative Printed Name:_____Date:_____
Personal Representative's Signature:_____
Relationship:_____

I authorize _____ (name) relationship _____ to obtain all/any health information regarding my care at Pentz Health Services dba Nevy Health. This authorization may include disclosure of information relating to alcohol, drug abuse, mental illness and confidential HIV related information only if I put my initial next to each box. I have the right to revoke this authorization at any time in writing to my health care provider. I understand that I may revoke this authorization except to extent that action has already been taken based on the authorization.

_____Entire Medical Records
_____ Alcohol/Drug Treatment
_____ HIV related Information
Other:_____
_____ Mental Health Information
_____ Genetic Testing

For Office Use Only

Complete this section if this form is not signed and dated by the patient or patient's personal representative.

Does Patient have a copy of the Privacy Notice? □ Yes □ No

If answered "No" above, I have made a good faith effort to obtain a written acknowledgment of receipt of Pentz Health Services LLC dba Nevy Health's Notice of Privacy Practices but was unable to for the following reason:
□ Patient refused to sign □ Patient unable to sign □ Other_____

Employee Printed Name:_____Date:_____
Employee's Signature: _____

This form should be placed in the patient's medical record

HEALTH HISTORY

*Name:*_____

Do you have Allergies? □ Yes □ No If yes, please list: _____

Are you taking any: Blood thinners □ Yes □ No Aspirin □ Yes □ No Non steroidal anti- inflammatory □ Yes □No

Please list and date any surgeries you have had, and diseases you have been diagnosed with: □ None _____

_____

Please list any Doctors you are seeing or have seen, please include contact number: _____

_____

Please state in your own words, the major medical reason(s) for coming in today:

_____

_____

Are you taking any: Medications? □ Yes □ No Supplements? □ Yes □ No
Please list all medication, including dosage, that you currently use:

_____

_____

_____

Do you have any drug allergies? Yes / No. If yes, please list:_____

_____

Family History; Please indicate the health or cause of death of members of your family as best as you can:

	Age	Any serious diseases? Please list	Cause of Death, if applicable, and Age of death.
Mother			
Father			
Brothers			
Sisters			
Children			
Spouse			
Other			

Have you had any significant problems in the following areas? If yes, please provide additional comments and dates of issues.

Recent weight loss □ Yes □ No _____

Headaches □ Yes □ No _____

Trouble with vision □ Yes □ No _____

Trouble with hearing □ Yes □ No _____

*Name:*_____

REVIEW OF SYSTEMS

Check the ones you now have or have had in the past:

General
- □ Abnormal weight loss/gain
- □ Alcoholism/drug abuse
- □ Allergies
- □ Blood/bleeding problems
- □ Breast lumps/soreness
- □ Cancer
- □ Depression/anxiety
- □ Diabetes
- □ Excessive thirst
- □ Fever/chills without flu
- □ General fatigue
- □ Night sweats
- □ Poor sleep
- □ Thyroid disease/goiter

Gastrointestinal
- □ Abdominal pain
- □ Appendicitis
- □ Belching/gas
- □ Black/bloody stools
- □ Constipation
- □ Diarrhea
- □ Gallbladder problems
- □ Hemorrhoids
- □ Hernia
- □ Liver problems/jaundice
- □ Frequent nausea/vomiting
- □ Pain over abdomen
- □ Poor appetite
- □ Poor digestion
- □ Ulcer/heartburn

Eye, Ear, Nose, and Throat
- □ Deafness/difficulty hearing
- □ Dental problems
- □ Ear noises/ringing
- □ Hoarseness
- □ Nosebleeds
- □ Nose problems
- □ Pain in/behind eyes
- □ Sinus problems/hay fever
- □ TMJ
- □ Tonsil problems
- □ Visual disturbances

Cardio-Respiratory
- □ Ankle swelling
- □ Asthma/wheezing
- □ Chest pains
- □ Chronic cough
- □ Difficulty breathing
- □ Emphysema
- □ High blood pressure
- □ High cholesterol levels
- □ Irregular heartbeat
- □ Previous heart trouble
- □ Rheumatic Fever
- □ Spitting phlegm/blood
- □ Stroke
- □ Tuberculosis
- □ Varicose veins

Skin
- □ Bruising easily
- □ Change in mole(s)
- □ Itching /eczema/rash
- □ Skin cancer

Genitourinary
- □ Blood in urine
- □ Difficulty starting flow
- □ Frequent urination
- □ Frequent night urination
- □ Inability to control flow
- □ Kidney disease/stones
- □ Painful urination
- □ Sexual difficulties
- □ Urinary tract infection
- □ Venereal infection

Women Only
- □ **Are you pregnant □ Yes □ No**
- □ Excessive flow
- □ Irregular cycles
- □ Hot flashes
- □ Painful periods
- □ PMS
- □ Vaginal burning/itching
- □ # of pregnancies _____ # of live births _____
- □ Date last menstrual period began

Men Only
- □ Testicular swelling/pain
- □ Prostate problems

Neurological
- □ Convulsions
- □ Dizziness
- □ Fainting
- □ Headache
- □ Mental disorder
- □ Numbness/tingling
- □ Twitching/tremors/epilepsy
- □ Weakness

Musculoskeletal
- □ Neck pain
- □ Pain between shoulders
- □ Low back pain
- □ Hip/knee/ankle/foot pain (circle all that apply)
- □ Osteoporosis
- □ Rheumatoid arthritis
- □ Shoulder/elbow/wrist/hand pain (circle)
- □ Scoliosis

Habits
- □ Smoking ____packs/day & years smoked_____
- □ Alcohol Drinks per week _____
- □ Exercise frequency_____
- □ Recreational drug use

Family History
(brothers, sisters, parents, grandparents only)
- □ Thyroid disease
- □ Cancer
- □ Diabetes
- □ High blood pressure
- □ Heart disease
- □ Stroke
- □ Kidney disease
- □ Muscle, bone, nerve, disease

I certify that all of the above questions were answered accurately. I understand that providing incorrect information may be dangerous to my health.

Patient Printed Name:_____Date:_____

Patient Signature (or Parent/ Guardian, if minor)_____

If a patient is not yet 18 years old, a parent or guardian must sign.

This form should be placed in the patient's medical record

INFORMED CONSENT of ACUPUNCTURE

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the Naturopathic Physician indicated below and/or other licensed Naturopathic physician or acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the physician named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Soft Tissue Massage, Guasha, Chinese herbal medicine, and nutritional counseling.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising, numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my physician and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, **results are not guaranteed, and there is no promise to cure**.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over the counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent from to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Please Initial that you acknowledge the following:

_____ **I am NOT pregnant or breastfeeding. I understand that it is my responsibility to inform the clinical team if I become pregnant.**

DO YOU HAVE A PACEMAKER? PLEASE CIRCLE: YES NO

_____ **I understand that having a Pacemaker is a CONTRAINDICATION for Electrical Stimulation and will inform the treatment team if I have a Pacemaker.**

_____ **I understand that Dr. Corey Skubisz (a male physician) may be providing me with the acupuncture treatment.** I understand that I have the right to ask for a "stand in" to accompany me and Dr. Corey Skubisz during my treatment. I understand that it is my responsibility to request a stand in prior to the appointment to ensure that there is staff available. If there is no staff available, I understand that it will be my responsibility to have a stand in accompany me to my appointment or reschedule the appointment until a stand in can be available.

Please Select:

☐ **I am NOT requesting a "stand in"** ☐ **I am requesting a "stand in"** ☐ **I will be providing a "stand in"**

Patient Name (Print): _____ Signature: _____ Date: _____

If patient is not yet 18 years old, a parent or guardian must sign

Clinician Name (Print): _____ Signature: _____ Date: _____