Hawthorn Holistic Health

2969 Whitney Ave., Suite 3B, Hamden, CT 06518

Dr. Lindsay Chimileski ND, LAc
Dr. Matthew Robinson ND

NEW PATIENT INTAKE FORM	Today's Date:
Name	Birthday
Name of Parents	
Address	Gender
	Home Phone
Occupation	Mobile
Who or what can we thank for referring you?	Email
Would you like to be automatically added to our online supplement store Fullscripts.com?	Which number are we authorized to a message on?
Is this your first time getting Acupuncture?	Are you Pregnant or trying?
Primary Care Physician & Phone Number	Below, circle your preferred Method for Appointment Reminders
Emergency Contact, Relationship & Phone Number	TEXT EMAIL PHONE CALL
List ALL Known Allergies	
	History of anaphylaxis?
List All Current Medications (with doses):	Current Vitamins & Supplements:
History of Hospitalizations & Surgeries	
Any Pre-existing Medical Conditions	
Insurance Information	
Name of Insurance Company:	Name of Insurance Policy Holder
ID# GROUP#	
Social Security Number (needed if on Medicare or Medicaid):	

Please Sign Every Page of this Form: _____date_____

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FAMILY HEALTH HISTORY Major illnesses, age or age of death
Mother & her parents
Father & his parents
Sibling(s)
Children

Chief Complaint for Today's Visit:
Health Goals:

Medical History	
Birth complications:	
C section- Yes or No?	Breast fed?
Food Allergies:	
Vaccination History:	
Major Illnesses:	

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CONSENT TO TREATMENT OF MINOR CHILD

I am the legal guardian of the following child and authorize Hawthorn Holistic Health LLC, Dr. Lindsay Chimileski, Dr. Matthew Robinson, and their assistants to administer treatment to my child:

_____
(Child's Name and Date of Birth)

Signed:_____Date:_____

Relationship:_____Phone Number:_____

Please Sign Every Page of this Form: _____date_____

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CONSENT TO TREAT:

Hawthorn Holistic Health, LLC is pleased to offer you a variety of in-office procedures and medical therapies.

Please read and initial the following statements to indicate you understand and consent to treatment:

_____ **Naturopathic Medicine, Nutritional, Vitamin, Supplement & Lifestyle Counseling**

_____ **Physical Medicine & Hands-on therapies including** massage, stretching, craniosacral, biocranial, myofascial release, Naturopathic Manipulation Therapy, hot/packs, contrast hydrotherapy, e-stim, ultrasound and joint mobilization.

Acupuncture & Traditional Chinese Medicine

_____ **Acupuncture**: insertion of sterile, one time use, solid needles to specific medically safe locations.

☐ I hereby request and consent to the performance of Acupuncture and Traditional Chinese Medicine (TCM) procedures by Dr. Lindsay Chimileski, ND. I have had the opportunity to discuss and understand the nature and purpose of Acupuncture and TCM treatments with the acupuncturist named above and/or with other office or clinic personnel.

☐ I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising, itching or tingling near the needling sites that can last a few days. I realize that although rare, there have been few instances fainting, infections, scarring, spontaneous abortion and pneumothorax.

☐ I understand it is imperative to tell the acupuncturist if I am PREGNANT or trying to get pregnant because although safe with pregnancy, specific rules and cautions must be used by the practitioners.

☐ I realize that Acupuncture and TCM is based on a different medical system than conventional doctors and visits to your primary care provider are still recommended. I wish to rely on the acupuncturist to exercise judgment based on his formal training to guide course of the treatment.

_____ **Cupping** : using glass or plastic cups to create suction to remove stagnation and adhesions in the underlying tissue. This often leaves the appearance of bruising (ecchymosis) and/or local tenderness that can last 2-7 days.

_____ **Moxibustion**: burning *Artemisia vulgaris*, or Mugwort, near or directly on the skin or acupuncture needle to promote circulation and warm the tissues. Rarely, this may cause first degree burning or skin blistering.

_____ **Gua Sha** : using massage tools to dredge superficial soft tissue (fascia and muscles) and remove adhesions in the underlying tissue. This often leaves the appearance of bruising (ecchymosis) that can last 2-7 days.

_____ **Tui-Na Chinese Massage**: using hands on soft tissue massage, active range of motion and acupressure to move qi and blood, remove stagnation and treat underlying disharmonies.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient or Guardian Print Name:_____**Date:**_____

Patient or Guardian Signature:_____ **Date:**_____

Please Sign Every Page of this Form: _____**date**_____

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ACKNOWLEDGEMENT OF PRIVACY 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)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I consent to the use or disclosure of my protected health information by Hawthorn Holistic Health LLC (HHH), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of HHH. I understand that diagnosis or treatment of my by any of the physicians at HHH may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. HHH's *Notice of Privacy Practices* is also available in our waiting room.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing, except to the extent that action has already been taken in reliance thereon.

Patient Name:_____Relationship to Patient: _____

Signature: _____Date: _____

Please Sign Every Page of this Form: _____date_____

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PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome and thank you for choosing Hawthorn Holistic Health as your healthcare provider. The doctors of Hawthorn Holistic Health (HHH) are participating providers with most insurance companies. Each insurance company sells many different policies, and these policies vary greatly regarding what they will cover.

As a courtesy, HHH will file your claim. After a claim has been filed the insurance company will respond with their decision about what they will cover. It has been our experience that insurance companies do not cover all of the services offered by naturopathic doctors. When insurance does not cover a provided service then you, the patient, will be billed for any charges not covered. You are also financially responsible for co-pays, deductible amounts, telephone consultations, lab work, missed appointment fees and supplements. There are some treatments offered at Hawthorn Holistic Health that are routinely not covered by most insurance companies.

These services include but are not limited to: Acupuncture, Hydrotherapy, Thermal Imaging
The fact that your insurance carrier may not pay for a particular item or service does not mean that you should not receive it. Your doctor may recommend it because it is a medically useful course of action. Please ask your doctor any questions regarding receiving services that may not be covered. You may elect to receive non-covered services with the understanding that you are ultimately financially responsible.

I hereby authorize Hawthorn Holistic Health LLC, to directly receive payment of pertinent insurance benefits; to release information including protected health information to insurance companies and other related third parties as needed in relation to patient diagnosis and treatment; and to convey information through various means as needed in accordance with the Notice of Privacy Practices, a copy of which was made available to me.

I acknowledge that I must give 24 hours notice to cancel an appointment. If I do not call within 24 hours of my appointment, a $50.00 charge (not billable to my insurance) will be billed to my account. I understand that this fee must be paid before I reschedule any appointment.

I hereby acknowledge that I am personally responsible for all co-payment, deductibles, non-covered services and required referrals according to my insurance policy. I agree to pay all applicable charges accrued and to promptly pay any balance in full. I understand that my account will be charged $25.00 for any checks returned due to non-sufficient funds. I also agree that I am responsible for any collection and/or attorney fees. I agree that I am responsible to promptly alert Hawthorn Holistic Health LLC., should there be any changes related to my insurance and other information I provided above.

_____ Date: _____.

Name and Signature of Responsible Party:

Please Sign Every Page of this Form: _____date_____

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ACUPUNCTURE Fees

Dear Patient:

If you consent to acupuncture treatment in the office, we will be collecting $20.00 in advance for treatment. We will bill your carrier, however some policy plans pay for the procedure and others do not. The standard acupuncture rate is $50.00 for every 15 minute CPT code applied.

- If your insurance pays for the treatment the $20.00 will be applied to the patient portion of the payment from the insurance carrier or if there is "no patient payment" portion, the $20.00 will be a credit on your account and can be used for other services or supplements.

- If your insurance considers the acupuncture treatment as "covered service" and applies the covered portion towards your deductible, you will be responsible to pay the portion that your insurance carrier applied to the deductible until you have met your deductible.

- If your insurance carrier does not cover acupuncture then the $20.00 will be applied as payment for the service.

Once we find out if your insurance pays for acupuncture, we will note it in the chart and will be able to know whether or not it is paid for by your insurance.

It is very hard to know in advance as to whether your insurance will pay for some of the specialty treatments such as acupuncture.

I, the patient, understand and agree to pay the $20.00 towards the acupuncture treatment. I agree to pay for my deductible if the insurance applied the service to the deductible or coinsurance. I understand I will have a credit of $20.00 if my insurance pays for all the acupuncture treatment.

INSURANCE: _____

Patient Signature: _____ Date: _____

Please Sign Every Page of this Form: _____date_____