



Patient History

Patient Name: _____ DOB: _____ Today's Date: _____

Phone Number: _____ Emergency contact/ Number: _____

Address: _____ Social Security # _____

What brings you in, please explain in detail? _____

Medical History: _____

Surgeries: _____

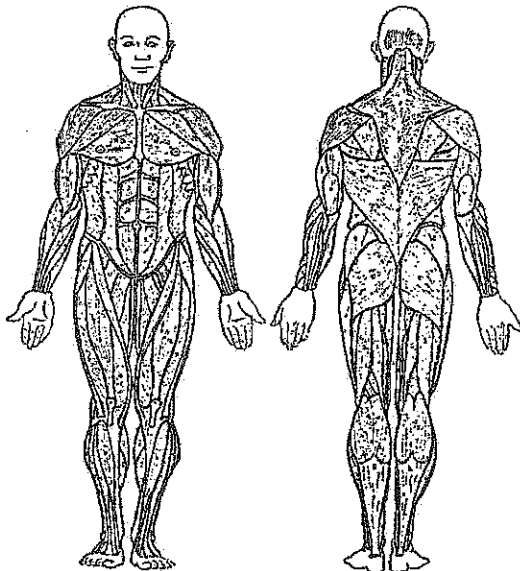
Allergies: _____

Medications and What it's for : _____

Are you on blood thinners or any heart medications? Yes / No Explain: _____

Do you have pain? Yes / No If yes, Describe it? _____

Indicate where the problem is:



How did it happen? _____

FAMILY AND SOCIAL HISTORY

LIST ANY SERIOUS ILLNESSES IN YOUR IMMEDIATE FAMILY. None
 (example: diabetes, tuberculosis, heart disease, cancer)

	RELATIONSHIP
_____	_____
_____	_____
_____	_____

Check One:	Yes	No
Do you smoke? (if yes, how much)	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink? (if yes, how much)	<input type="checkbox"/>	<input type="checkbox"/>
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>
Occupation	_____	

REVIEW OF SYSTEMS

Do you currently have any of these symptoms? Check YES or NO. Please explain any YES answers in the space provided

CARDIOVASCULAR: Yes No

Chest Pain

Varicose Veins

High Blood Pressure

Other _____

CONSTITUTIONAL: Yes No

Fever

Chills

Headache

Other _____

EYES: Yes No

Blurred Vision

Double Vision

Eye Pain

Other _____

GASTROINTESTINAL: Yes No

Abdominal Pain

History of Ulcers

Indigestion/Heartburn

Nausea/Vomiting

Other _____

GENITOURINARY: Yes No

Urine Retention

Painful Urination

Urinary Frequency

Other _____

**HEMATOLOGIC/
LYMPHATIC:** Yes No

Swollen Glands

Blood Clotting Problem

Other _____

INTEGUMENTARY: Yes No

Skin Rash

Bolls

Persistent Itch

Other _____

MUSCULOSKELETAL: Yes No

Joint Pain

Neck Pain

Back Pain

Other _____

NEUROLOGICAL: Yes No

Tremors

Dizzy Spells

Numbness/Tingling

Other _____

PSYCHOLOGICAL:

History of Depression YES NO

Sleep Disturbances YES NO

Anxiety Disorder YES NO

Other _____

RESPIRATORY: Yes No

Wheezing

Frequent Cough

Shortness of Breath

Other _____

PHYSICIAN USE ONLY: (Comments/Notes)

X

Signature of Patient/Authorized Individual

Date

VITAL SIGNS:
 (To be completed by Medical Assistant)

Temp: _____

Pulse: _____

Weight: _____

Initial: _____

Physician _____ Date _____ / _____ / _____
 Signature



Health Wish

Basic Intal

Date _____	Reason for Appointment _____
Patients Name _____	Left _____ Right _____
Address _____	Date of Injury _____
Town _____ State _____ Zip _____	Duration of Problem _____
Telephone: Home () _____	Have any of the following been done:
Work () _____	Xrays: Yes _____ No _____
Cell () _____	Facility _____
Date of Birth _____	MRI: Yes _____ No _____
Age _____	Facility _____
Social Security # _____	Do you have:
Patient's/Guardian (if patient is under 18 years of age) _____	Films: _____ Reports: _____

Referring Doctor _____	Family Doctor _____
Address _____	Address _____
Town _____ State _____ Zip _____	Town _____ State _____ Zip _____
Telephone () _____	Telephone () _____

Name of Insurance Company: _____	Did you report your accident to your carrier? Yes _____ No _____
Address _____	Did you complete a NF2 form? Yes _____ No _____
Town _____ State _____ Zip _____	Policy # _____
Telephone () _____	Policy Holder _____
Date of Accident _____	File/Claim # _____
Claim Representative _____	

PRIVATE INSURANCE INFORMATION

Primary Insurance _____	Secondary Insurance _____
Name of Insured _____	Name of Insured _____
Relationship to Patient _____	Relationship to Patient _____
SS # of insured _____	SS # of insured _____
Date of Birth of Insured _____	Date of Birth of Insured _____

I authorize the release of any medical information necessary to process an insurance claim and authorize direct payment to Health Wish Acupuncture And Massage Therapy, PLLC. I understand that I am financially responsible for treatment rendered.

Patient's signature: _____ Date: _____

1. INDIVIDUAL'S RESPONSIBILITY FOR NON-COVERED SERVICES

In consideration of services rendered by Health Wish Acupuncture and Massage Therapy, PLLC I, the undersigned, agree to pay for all services that are not covered by my Health. Insurance Plan Provided I am informed of same prior to the rendering of said services.

2. ASSIGNMENT OF BENEFIT PROCEEDS

I hereby assign to Health Wish Acupuncture and Massage Therapy, PLLC all monies and / or benefits to which I am entitled from my insurer/HMO/third party payer, government agencies, or those who are financially liable for my medical care.

Signature of Patient or Authorized Representative: _____

Date _____

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____, ("Assignor") hereby assign to _____, ("Assignee")
(Print patient's name) (Print hospital or health care provider name)

all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
(Print accident date)

to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

(Print name of Patient)

(Signature of Patient)

(Date of signature)

(Address of Patient)

(Print name of Provider)

(Signature of Provider)

(Date of signature)

(Address of Provider)

Patient Name: _____ DOB: _____

This letter has been provided to help assist you in understanding that with today's ever changing insurance coverage, most plans do not financially cover your visits in full. Patients are responsible for copy's, coinsurances, deductibles, and out of pocket expenses.

As a patient, it is your responsibility to know your specific insurance plan and what your financial responsibility will be for each visit, each procedure and/or any product that you receive.

It is your responsibility to know if the acupuncturist you are seeing participates and accepts your medicinal insurance.

At today's visit with Health Wish Acupuncture and Massage Therapy, you may be required to pay one or two co payments if any services, equipment, or supplies have been provided for you.

Health Wish Acupuncture and Massage Therapy will be collecting your copayment as indicated on your insurance card. Please be aware that there may be additional charges due depending on your insurance policy. It is always important to read your explanation of medical benefits (your insurance receipt) that you receive from your carrier indicating our charges and their payments.

On this letter from your carrier, it will indicate the following:

- The total charges billed to your medical insurance company.
- The amount your insurance company allows.
- The amount your insurance company has adjusted.
- The amount our insurance company has paid to us.
- The amount your are responsible to pay to your acupuncturist.

Also, this area will indicate the amount that was applied towards your deductible, company, coinsurances, or put of pocket expense.

Please note that these amounts are determined by your health insurance plan that you purchased to cover your medical needs.

New York State does not allow us to waive any of these charges.

By signing below, I understand and accept the terms and conditions as written above. I am aware that if I do not pay my portion in full, Health Wish Acupuncture and Massage Therapy will balance bill me. I acknowledge that it is my responsibility to be informed of my medical insurance coverage.

Patient Signature _____ Parent/Guardian is under 18 _____ Date _____

Out of network plans:

If your medical insurance has out of network benefits and you agree to see an acupuncturist who does not participate with your carrier, please sign below acknowledging that you agree to pay your doctor the amount your insurance will forward to you plus any out of network payment. Please also bring the Explanation of Benefits with said payment.

Patient Signature

Parent/Guardian if under 18

Date

If you have been injured in a sport related incident, school, camp or town activity, please note that we do not third party bill. You are financially responsible for all charges according to your insurance policy agreement. Once all fees are paid by both you and your insurance carrier, a receipt will be issued so you may submit for reimbursement to the third party involved.

Personal injury patients are financially responsible for all services rendered. Once charges are paid in full to Health Wish Acupuncture and Massage Therapy, a receipt will be provided to you to settle your claim with any outside party involved.

Workers' Compensation Injuries:

You are responsible to provide Health Wish Acupuncture and Massage Therapy all claim information. If this information is not received at your initial visit, we will collect \$250.00 fee (payable in cash or credit card only). A refund in this amount will be issued once all your no fault information is received and verified.

No-Fault Injuries:

You are responsible to provide Health Wish Acupuncture and Massage Therapy all no fault claim information. If this information is not received at your initial visit, we will collect \$250.00 fee (payable in cash or credit card only). A refund in this amount will be issued once all your no fault information is received and verified.

Private insurance information will also be collected for coverage if for any reason your worker compensation/ no fault claim is rejected.

Patient Signature

Parent/Guardian if under 18

Date



Consent For Treatment

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and Traditional Chinese Medicine by a Licensed Acupuncturist at Health Wish.

I hereby authorize and direct Mehwish Chughtai, LAc, LMT, Herbalist to perform Acupuncture, Massage, and Oriental Medicine procedures for cosmetic purposes. These procedures include, but are not limited to, obtaining a health history, performing pulse and tongue evaluation, manual palpation, observation of skin and muscles, "Chi" assessment, modes of manual and natural therapy, such as Tui Na and Shiatsu massage, cupping, topical application of liniments and creams, dietary recommendations and advice regarding lifestyle and exercise.

Facial Rejuvenation Acupuncture consists of cleaning the area with a topical exfoliant to remove any makeup, dirt or debris. Alcohol is not used to cleanse the area due to it's drying properties. Insertion of sterile disposable needles will then be inserted into specific site on the face and body. Stimulation of said needles may be achieved by hand manipulation, electrical stimulation or the application of warming substances (moxa) on the needle itself. The face masks used in this procedure are individually packed presoaked masks. The cream used to massage the area at the end of the procedure is a vitamin cream. I understand that if I have any reaction to said mask or cream, I will let Health Wish know immediately.

Acupuncture: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or disease, signs of aging, to modify and prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Cupping: I understand that if I receive cupping as part of therapy, there is a likelihood of bruising and / or discoloration on the body-area on which the cupping is performed. There may also be a slight probability of discomfort from this procedure. I understand that I may refuse this therapy.

Massage: I understand that I may also be given massage as part of my treatment. I am aware that certain adverse side effects may result from this treatment. These may include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

I have had the opportunity to discuss questions with my practitioner, regarding the nature and purpose of acupuncture, cupping, massage, and oriental medicine procedures. I understand that although acupuncture, cupping, massage, and oriental medicine procedures have helped many people, no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of western medicine, in the practice of Oriental Medicine there are some risks to treatment. I understand that the risks include, but are not limited to: bleeding, bruising, light-headedness, inflammations, infections, general aches, allergic reactions, burns, discomfort at the location where the needle was inserted/ cupping was performed or radiating from that location and temporary aggravation of current symptoms. I do expect the practitioner to be able to anticipate and explain all risks and complications, and during the course of treatment I wish to rely on the practitioner's judgement based on the facts known at the time.

I, _____, certify that I have read and understood the above consent. I also certify that I have informed my acupuncturist of all known physical, mental and medicinal conditions and medications, and I will keep her dated on any changes. I further understand that this consent will remain in effect until such time that I choose to terminate treatment.

Signature: _____ Date: _____



Notice 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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services. They include but are not limited to the following disclosure and uses.

Example of uses of your health information for treatment purposes:

A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of use of your information for health care operations:

We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your health information rights:

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed a copy of your health and billing record -- you may exercise this right by delivering the request in writing to our office; Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office; File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care; communication of your health information made by alternative means or at an alternative location by delivering the request in writing to our office; and
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our office at (516) 279-0918 during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and accommodate your reasonable requests regarding methods to communicate health information with you.
- We reserve the right to amend, change, or eliminate provisions in our privacy practices, access practices, and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice.
- You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.



Health Wish

HIPAA
Privacy Practice

Notice of Privacy Practices for Protected Health Information - Continued

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our office at (516) 279-0918. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office. You may also file a complaint by mailing it or e-mailing (healthwish123@gmail.com) it to our office. We cannot, and will not, require you to waive the right to file a complaint with us as a condition of receiving treatment from the practice. We cannot, and will not retaliate against you for filing a complaint with us.

Other Disclosures and Uses

Notification Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family Using our best judgement, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency

Food and Drug Administration (FDA) We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement We may disclose your protected health information for law enforcement purposes required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial / Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceedings as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website If we maintain a website that provides information about our entity, this Notice will be on the website.

Patient's Signature: _____

Acupuncturist's Signature: _____