Health Wish

Basic Intake

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 : ____

____

____

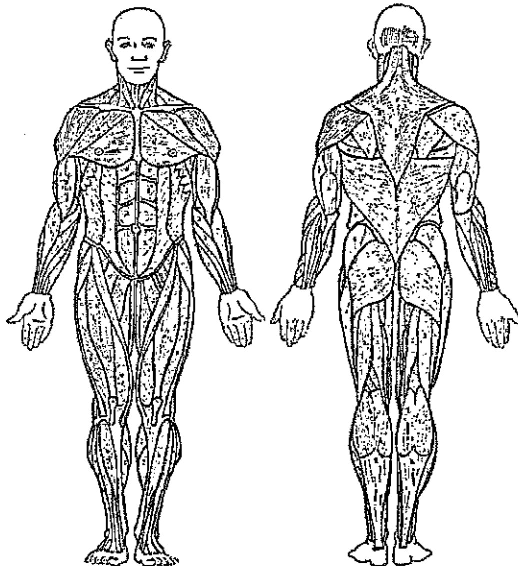
____

____

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)

Illness	RELATIONSHIP

Check One:	Yes	No
Do you smoke?	☐	☐
(If yes, how much) ______		
Do you drink?	☐	☐
(If yes, how much) ______		
Do you live alone?	☐	☐
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	☐	☐
Boils	☐	☐
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

OVER ⇨

Health Wish

Basic Inta

DATE ______________

Patient **Last name** ______________ **First** ______________ DOB ________ **Age** ______

Parent or Guardian (if under 18) ______________ Contact Phone # ______________

Address ______________ **City** ______________ **State** ________ **Zip Code** ________

Home Phone # ______________ Work # ______________ Cell # ______________

S.S. # ______________ Male _____ Female _____ Employer ______________

Referring Physician ______________ Address ______________

Telephone # ______________ Fax # ______________

Primary care physician (if different from referring physician) ______________

Address ______________ Telephone # ______________ Fax # ______________

BODY PART ______________ **RIGHT / LEFT (*CIRCLE*)**

Date of Injury ______________ **Duration of Problem** ______________

Seen in Emergency room? YES OR NO (*CIRCLE*) Date ______________ **Name of Facility** ______________

X-Rays Taken ? YES OR NO Date ______________ **Facility** ______________

MRI/ CT SCAN Taken? YES OR NO Date ______________ **Facility** ______________

Pharmacy Name ______________ **Telephone #** ______________ **Address** ______________

COMPENSATION INSURANCE INFORMATION

Name of Insurance Company ______________ Address ______________

Date of injury ______________ Contact Person ______________ Contact Telephone(____) ______________

Did you report your injury to your Employer? Yes ____ No ____ Are you currently working? Yes _____ No _____

Policy # ______________ Case# ______________ Date last worked: ______________

Name of Employer: ______________ Address: ______________

Telephone# (_____) ______________ Contact Person: ______________

PRIVATE INSURANCE INFORMATION:

Name of Insurance Company ______________ Policy # ______________

Name of Policy Holder ______________ Relationship to Patient ______________

DOB of Policy Holder ______________ S.S. # of Policy Holder ______________

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

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL §32 IS APPROVED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY	NATURE OF INJURY OR ILLNESS	INJURED PERSON'S SOC. SEC. NO.

CLAIMANT	NAME	ADDRESS APT. NO.
EMPLOYER		
INSURANCE CARRIER		

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law §32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/ services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the provider's fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature ______________________________ Date ______________

Provider's Name and Address ____

____

TO THE CLAIMANT

Workers' Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employer or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employer or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under a Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

TO THE HEALTH CARE PROVIDER

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimant's responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 Agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision finding that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved.

DOWNSTATE CENTRALIZED MAILING
(for New York City, Hempstead, Hauppauge & Peekskill Districts)
PO Box 5205 Binghamton, NY 13902-5205
NYC (800)877-1373 / Hemp. (866)805-3630 / Haup. (866)681-5354 / Peek. (866)746-0552

100 Broadway, Menands, ALBANY 12241, (866) 750-5157
State Office Building, 44 Hawley Street, BINGHAMTON 13901, (866) 802-3604
369 Franklin Street, BUFFALO 14202, (866) 211-0645
130 Main Street W., ROCHESTER 14614, (866) 211-0644
935 James St., SYRACUSE 13203, (866) 802-3730

State of New York
WORKERS' COMPENSATION BOARD

CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS

(Pursuant to Workers' Compensation Law Section 110-a)

PLEASE COMPLETE ALL ITEMS. AN INCOMPLETE FORM WILL DELAY THE PROCESSING OF YOUR REQUEST.

Claimant's Name	Claimant's Social Security No.	Case Number and/or Date of Accident ☐WCB ☐DB ☐Discrimination

IF RELEASE IS AUTHORIZED FOR ADDITIONAL CASE FILE(S), IDENTIFY BELOW BY WCB/DB/DC CASE NUMBER AND/OR DATE OF ACCIDENT(S).

CLAIMANT IS PROHIBITED FROM AUTHORIZING RELEASE OF WORKERS' COMPENSATION INFORMATION TO PROSPECTIVE EMPLOYERS OR IN CONNECTION WITH ASSESSING FITNESS OR CAPABILITY OF EMPLOYMENT.

INSTRUCTIONS:
Submit original to the Workers' Compensation Board and retain a copy for your records. *Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a on the reverse of this form.* This authorization is effective until it is revoked by the claimant. Claimant may revoke this authorization at any time upon written notice to the Workers' Compensation Board.

THIS AUTHORIZATION DOES NOT PERMIT YOU TO OPEN AN INDIVIDUAL eCASE ACCOUNT OR TO VIEW CASES VIA eCASE OUTSIDE OF A BOARD LOCATION.

Pursuant to Section 110-a of the Workers' Compensation Law, I, ______________________________,
Claimant's Name

represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced Workers' Compensation Board records with and/or release a copy of the above-referenced records to

____, at
Name of a Specific Person, Corporation, Association or Public or Private Entity

____.
Address

I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

____ ____________________
Claimant's Signature (ink only – use blue ballpoint pen if possible) Date

Failure to provide the information requested on this form will not result in the denial of your authorization, but may delay the processing of your request. The voluntary release of your social security number enables the Board to ensure that information is associated with, and quick action is taken on, your request.

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 your agree to see an acupuncturist who does not participate with your carrier, please sign below acknowledging that your 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 not 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:
Your 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:
Your 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

Health Wish

Mehwish Chughtai
LAc, LMT, Herbalist

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 preformed. 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:________________________

Health Wish

HIPAA
Privacy Practice

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 be 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 and 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 requires 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 informations 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 reserves 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.
- Your 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 your 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 filling 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 your 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 it's 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: ______________________________