The Apothecary at Easton, LLC

Confidential Intake Form			
Patient Information			
Name:	Gender: M☐ F☐	Date of Birth:	Age:
Address:			
City:	State:	Zip:	
Daytime Phone	Evening Phone		
Mobile Phone	Fax		
Email			
Physician	Referred by		
Physician's Address			
City:	State:	Zip:	
Emergency Contact	Phone	Relationship	
Insurance Information			
Insurance Carrier:	Insurance Phone (for providers):		
Member ID:	Group Number:		
Workman's Compensation			
Insurance Carrier:	Insurance Phone (for providers):		
Adjuster's Name:	Adjuster's Phone:		
Member ID:	Group Number:		
Social Security Number:	Date of Injury		
Diagnosis:			
Personal Injury			
Date of Injury:	Other Person's Name		
Insurance Carrier:	Insurance Carrier:		
Adjuster's Name:	Adjuster's Name:		
Adjuster's Phone Number:	Adjuster's Phone Number:		
Policy Number:	Policy Number:		
Claim Number:	Claim Number:		
Social Security Number:	Diagnosis:		

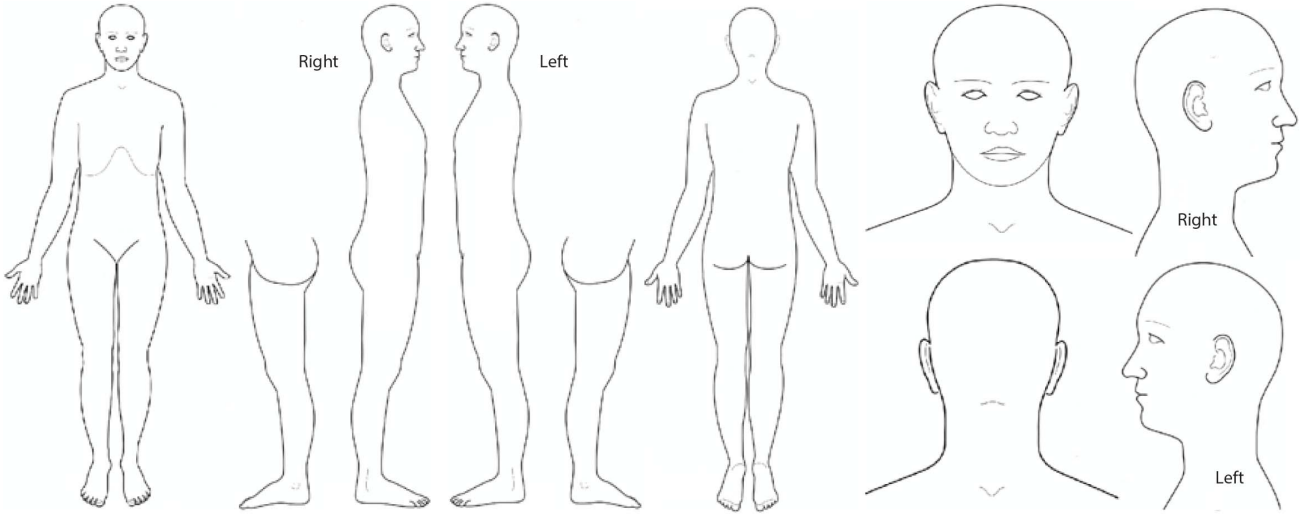
Official Use Only (below)

History of Present Condition(s):

What is the primary complaint you want treated with acupuncture today?

Location:

Where are you experiencing symptoms:



Quality:

☐ Sharp	☐ Stiff	☐ Dull	☐ Achy	☐ Burning	☐ Tingling
☐ Numb	☐ Nagging	☐ Radiating/referral	☐ Local	☐ Other:	

Severity:

0 1 2 3 4 5 6 7 8 9 10

Completely able to Function — Mild — Moderate — Severe — Completely unable to Function

Duration:

How long have you had symptoms?

Is this the first time or a (re)exacerbation? (explain):

Progression of Symptoms:

Is the condition getting worse, better, remaining the same? If better or worse describe:

Timing/Frequency:

☐ Occasional – Up to 25% of time	☐ Intermittent – Up to 50% of time
☐ Frequent – Up to 75% of time	☐ Constant – up to 100% of time

Please describe if there is a pattern to the intensity of your symptoms:

Context:

Date of injury (day/month/year) if insidious onset please provide approximate time of initiation of symptoms:

How did the symptoms start?

Modifying Factors:

☐ Better with Heat ☐ Worse with Heat	☐ Better with Cold ☐ Worse with Cold	☐ Worse in the morning ☐ Worse during the day	☐ Worse at night ☐ Worse with fatigue
☐ Better with Rest ☐ Better with Activity	☐ Better with Pressure/Massage ☐ Worse with Pressure/Massage	☐ Other Modifying Factors (explain):	

Associated Signs/Symptoms: (headaches, nausea, etc…)

Past Medical History

- ☐ Alcoholism/Drug Abuse
- ☐ Allergies
- ☐ Anemia/Blood Disorder
- ☐ Anxiety
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Bell's Palsy
- ☐ Blood Clots
- ☐ Cancer/Tumors
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis/Irritable Bowel
- ☐ Congestive Heart Failure
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Heart Surgery
- ☐ Headaches/Migraines
- ☐ Hepatitis A/B/C (circle one)
- ☐ Hernia
- ☐ Herpes Oral/Genital (circle one)
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Lupus
- ☐ Lyme's Disease
- ☐ Lymph Nodes Removed
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Pacemaker
- ☐ Peripheral Vascular Disease
- ☐ Parkinson's Disease
- ☐ Polio
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Singles
- ☐ Seizures
- ☐ Stroke/CVA/TIA
- ☐ Tuberculosis
- ☐ Other: _____

Please describe any significant injuries, surgeries, or major illnesses, whether hospitalized or not. Include approximate dates:

_____

_____

_____

_____

_____

_____

_____

Family History: (Please list any significant family illnesses.)

Father: _____

Mother: _____

Siblings: _____

Grandparents: _____

Your Children: _____

Social History: ☐Married ☐Divorced ☐Single☐ Cohabitating ☐ Caretaker Child(ren)/Adult Explain_____

☐Non-Smoker (never smoked) ☐ Ex-Smoker ☐ Current Smoker ☐ How many packs per day? _____ ☐ How years?_____

Recreational Drug Consumption: ☐Never ☐Occasional ☐Frequent

How many glasses/cups do you have: Water_____daily Caffeinated beverages _____ daily/ weekly *(Circle One)* Alcohol _____ daily/week *(Circle One)*

Occupation:

Are you allergic to any medications: No ☐ Yes ☐ Please list any allergies and adverse reactions to medication or other substances:

_____

_____

_____

Current Medications, Supplements, Herbs	*For Treatment of:*

ROS	(-)	Please check all **CURRENT** positive findings
Constitutional		☐Weight Loss ☐ Weight Gain ☐ Fever ☐ Chills ☐ Poor Appetite ☐ Fatigue ☐ Insomnia ☐ Night Sweats
Eyes		☐Blurry vision ☐Eye pain ☐Eye redness ☐Decrease in vision ☐Dry eyes ☐Double vision
ENT		☐Sore Throat ☐Hoarseness ☐Ear pain ☐Hearing Loss ☐Ear Discharge ☐Nose Bleeds ☐Tinnitus ☐Sinus Problems
Cardiovascular		☐Chest Pain ☐Palpitations ☐Rapid Heart Rate ☐Heart Murmur ☐ Poor Circulations ☐Swelling in the Legs or Feet
Respiratory		☐Shortness of Breath ☐Chronic Cough ☐Coughing up Blood ☐History of Tuberculosis ☐Excess Sputum Production
Gastrointestinal		☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Blood in the Stool ☐Frequent Heartburn ☐Trouble Swallowing
Genitourinary		☐Increased Urinary Frequency ☐Blood in the Urine ☐Incontinence ☐Painful Urination ☐Urinary Retention ☐Frequent UTIs
Skin		☐Rash ☐Hives ☐Hair Loss ☐Skin Sores or Ulcers ☐Itching ☐Skin Thickening ☐Nail Changes ☐Mole Changes
Musculoskeletal		☐Joint Pain ☐Muscle Aches ☐Frequent Leg Cramps ☐Muscle Weakness ☐Bone Pain ☐Joint Swelling ☐Back Pain
Psychiatric		☐Anxiety ☐ Panic Attacks ☐Depression ☐Irritability ☐Outburst of Anger ☐Poor Memory ☐Difficulty Concentrating ☐Feeling Overwhelmed
Endocrine		☐Goiter ☐Heat Intolerance ☐Cold Intolerance ☐Increased Thirst ☐Change in Skin Pigment ☐Excess Sweating
Neurological		☐Seizure ☐Tremors ☐Migraines ☐Numbness ☐Dizziness/Vertigo ☐Loss of Balance ☐Slurred Speech ☐Stroke
Hem/Lymphatic		☐Low Blood Count ☐Easy Bruising ☐Swollen Lymph Nodes ☐Transfusions ☐Prolonged Bleeding ☐Blood Clots
Allergic/Immune		☐Allergic Reactions ☐Hay Fever ☐Frequent Infections ☐Hepatitis ☐HIV positive ☐Positive Tuberculin Skin Test (PPD)

Additional Information: Use this space to provide any additional information that may be important to your health care.

Signature of Patient Date

Kathleen Smith M.Ac. L.Ac. LMT Date
Signature of Reviewing Physician

Cancellation Policy
For
The Apothecary at Easton, LLC

Booking an appointment means that you have read and agree to the following policy:

Thank you for trusting your health and wellness to The Apothecary at Easton, LLC; we truly appreciate your patronage. An appointment in our facility is viewed as a commitment between the practitioner and patient. Appointment times have been reserved especially for you. We fully respect your time and ask that you do the same for ours.

We REQUIRE 24 hours notice in order to cancel or reschedule an appointment. While we understand that emergencies happen, late cancellations and missed appointments greatly impact our business.

Fee for missed appointments:
You may cancel or change your appointment up to 24 hours in advance of your treatment by calling, leaving a voice message or a text message on the office phone. For changes, cancellations, and any no call/no shows within the 24 hour window prior to your scheduled time, **you will be charged the cost of your service.** Please understand that we use high quality products that cannot be reused once prepared. We must also pay our practitioners for their time regardless of whether the client is present for their appointment or not. Please note that any balances on your account must be paid before another appointment will be scheduled or administered.

Late Arrivals:
Unfortunately, we are unable to extend treatment time for late arrivals. If you arrive late, you will receive the remainder of your service time and you will be billed for the regular cost of the service. We encourage patients to arrive 5-10 minutes early for services. Thank you for your understanding.

Same day appointments:
Appointments made same day are **non-refundable** once scheduled. The Apothecary will "hold" a time slot for a patient for 30 minutes, in good faith. If communication is not received within the allotted time frame, the hold will be released and the time slot will be made available for other patrons.

Insurance Patients:
Insurance benefits are not a guarantee of payment. You may have a deductible, out-of-pocket liability, or other stipulations required by your insurance provider. While we are happy to assist with the verification of benefits, it is the patient's responsibility to know and understand the parameters of their specific policy. This information can be accessed by calling the patient services number located on the back of your insurance card. In the event an insurance company will not pay for services, patient understands that they are responsible for the cost of their service. All patient accounts must be paid in full before scheduling another appointment. Insurance billing is a time consuming and expensive process that we adamantly believe is important in bringing wellness care to a broader audience.

Late Fees:
All balances on your account after 30 days will begin to accrue monthly late fees, which will be 10% of your **original bill**. Billing will be processed in increments of 30 days with compound interest after 30 days.

I, _____ have read and understand the policy above.
I will remain financially responsible for the payment in full prior to receiving my next treatment.

CC #: _____ Exp. Date: _____ 3 digit pin: _____ Zip code: _____
Date Signed: _____

Insurance Verification Page

Name of Patient and Patient ID #_____

Insurance provider:_____ Provider Services #:_____

Does the patient have acupuncture benefits? (Note: if the answer is NO, end your call here. If the answer is YES, continue below)_____

What is their copay (flat out-of-pocket rate for patient) or coinsurance (percentage of total fees patient is expected to pay)?_____

How much is covered after the copay or coinsurance? (Generally, the answer is “100% of allowed amount after copay/coinsurance.”)_____

What is their per-calendar-year benefit for acupuncture?_____

Is this benefit combined with other CAM treatments?_____

Has any of this policy benefit been used to date and if so, how much is remaining?_____

Is acupuncture treatment subject to a deductible? If so, what is the patient’s annual deductible, and how much of the deductible has been met?_____

Is acupuncture covered when performed by a Licensed Acupuncturist?_____

Are there any exclusions to treatment? (i.e. weight-loss treatment, etc.)_____

Are these specific diagnosis codes covered?(ex. 97810,97811)_____

Verify claims mailing address, especially if you are out of network or it isn’t listed on the card._____

Insurance Representative Contact History

Date:_____ Name:_____ Confirmation # _____
Date:_____ Name:_____ Confirmation # _____
Date:_____ Name:_____ Confirmation # _____
Date:_____ Name:_____ Confirmation # _____
Date:_____ Name:_____ Confirmation # _____
Date:_____ Name:_____ Confirmation # _____
Date:_____ Name:_____ Confirmation # _____