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WELLNESS

MEDICAL HISTORY INTAKE FORM

Today's Date	

Patient Name		Date of Birth	
Phone No.		Email	
Address			
City		State	ZIP

Emergency Contact	
Relationship	Phone

How did you hear about us? Specify: _____

- ☐ Primary Care Physician
- ☐ Specialist Physician
- ☐ Hospital / Urgent Care
- ☐ Insurance
- ☐ Doctor
- ☐ Friend / Family
- ☐ Employer
- ☐ Lawyer
- ☐ Health Fair / Street Fair
- ☐ Signage
- ☐ Newspaper
- ☐ Online
- ☐ Google
- ☐ Bing
- ☐ Yahoo
- ☐ Facebook
- ☐ Instagram
- ☐ Groupon
- ☐ Zocdoc
- ☐ Healthgrades
- ☐ Yelp

Consent to treat

I _____ do hereby authorize the physicians and healthcare providers at Hudson Wellness to administer such care that is necessary for my particular case. This care may include consultation, acupuncture, or any other procedure which is advisable and necessary for my healthcare. Prior to any procedures the risk benefits and alternatives have been discussed in detail.In signing below, I consent to any requested procedures.

Signature	Date

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CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH OPERATIONS

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. Hudson Wellness maintains the privacy of patient health information. I understand that this information serves as:

- **A basis for planning my care and treatment**
- **A means of communication among the many health professionals who contribute to my care**
- **A source of information for applying my diagnosis and surgical information to my bill**
- **A means by which a third-party payer can verify that services billed were actually provided**
- **A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals**

I understand a *Notice of Privacy Practices* is available upon request which provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to object to the use of my health information and directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereof.

Patient, Parent / Guardian Signature	**Date**

*If pregnant, please notify the Doctor before treatment

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CANCELLATION POLICY

We understand that unanticipated events may happen. However, appointments that are missed and not cancelled prevent other guests access to our facility. In order to provide wellness services to as many guests as possible, we require **24 hours advanced notice** for cancellation.

If you are unable to provide **24 hours** advanced notice for cancellation, you will be charged a **$25** cancellation fee.

To change or cancel an appointment, please call our office at **646-882-6278** as soon as possible.

I understand that I will be charged a cancellation fee of $25 in the event that my appointment is not cancelled within the above mentioned time frame. A credit card authorization will be held on file to accommodate the charge. This fee must be paid in full prior to future services and appointments.

Office and Financial Policies

Payment

Payment is expected at the time of your visit. We will accept cash or credit card. Payment will include any unmet deductible, co-insurance, co-payments amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing insurance clause, payment in full is expected at the time of your visit. A copy of a valid ID card or license is required for identification purposes.

Insurance

We will file all insurance claims. Please remember that insurance is a contract between the patient and the insurance company and the patient is ultimately responsible for the payment in full. If your insurance company does not pay the practice in a reasonable amount of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment.

If our providers are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and submit the claim for you on an unassigned basis. This means the insurer may send the payment directly to you.

Please contact the office immediately when you receive a check from your insurer.

Verification of insurance benefits is an estimate, therefore we cannot guarantee your eligibility and coverage. We suggest you check your individual insurance benefits regarding covered services and providers prior to your appointment. You are responsible for obtaining a properly dated referral if required by your insurer. Furthermore, you are responsible for payment if your claim is rejected for lack of proper referral documentation.

Signature	Date

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CREDIT CARD AUTHORIZATION FORM

Please complete and sign this form to authorize Hudson Wellness to charge your debit or credit card listed below. By signing this form, you give permission to debit your account for any copays or balances.

I, _____ authorize Hudson Wellness to keep my credit or debit card on file to charge for any copays or balances on my account.

Account Type

☐ VISA ☐ MasterCard ☐ AMERICAN EXPRESS ☐ DISCOVER

Cardholder Name	
Account Number	
Expiration Date	
CVV2 (3-digit code on back of Visa/MC, 4-digit code on front of AMEX)	

Billing Address	

City		State		Zip Code	

Phone	

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company, so long as the transaction corresponds to the terms indicated in this form.

Signature	Date

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MEDICAL HISTORY INTAKE FORM

Primary Reasons for Visit:

1		2	

Allergies to Medications, Food or the Environment:
(If none please check ☐ **NONE**)

DRUG	REACTION

Current Medications:
(Include over the counter meds, vitamins, and supplements ☐ **NONE**)

MEDICATION	DOSE OR AMOUNT	FREQUENCY

Past Medical History: Please Include the YEAR diagnosed (If none please check ☐ **NONE**)

_____ Anemia
_____ Anxiety
_____ Arrhythmias
_____ Asthma
_____ Back Pain
_____ Bleeding Disorders
_____ Blood Clots
_____ Cancer
_____ Coronary Artery Disease
_____ Depression
_____ Diabetes
_____ GERD(reflux)
_____ High Blood Pressure
_____ High Cholesterol
_____ Liver Disease
_____ Migraine/ Headaches
_____ Osteoarthritis
_____ Osteoporosis
_____ ADHD
_____ Seasonal Allergies
_____ Stroke
_____ Thyroid Disease
_____ Other _____

Past Surgical History: Please include the YEAR (If none please check ☐ **NONE)**

1. _____
2. _____
3. _____

Family History: Identify the AGE (or age of death) and describe the history of chronic diseases if present
(**Example** - *Father alive 78 with a history of Diabetes, Heart Disease and Cancer etc.)*

Father _____
Mother _____
Siblings _____

Social History:

Occupation _____ Any Work Restrictions _____

☐ Full Time ☐ Part Time ☐ Retired/When _____

Marital Status _____ Children: ☐ Yes ☐ No #Boys _____ #Girls _____

Tobacco Use: ☐ Yes ☐ No Quit When _____ Packs per day _____

Alcohol Use: ☐ Yes ☐ No Average number of drinks per week _____

Illicit Drug Use: ☐ Yes ☐ No What _____

Exercise: ☐ Yes ☐ No Types _____ Days per week _____

Health Maintenance: Please list the **DATE** of most recent (place N/A for non-applicable questions)

Height _____ Weight _____

Prior evaluation with a Chiropractor or Acupuncturist _____ Who? _____

Men's Health; year of last- Colonoscopy _____ Prostate _____ PSA _____

Woman's Health; year of last- Colonoscopy _____ PAP _____ Mammo _____

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MEDICAL HISTORY INTAKE FORM

1. When did your symptoms appear?

2. Is this condition getting progressively worse?

3. Type of Pain:

- [ ] Sharp
- [ ] Dull
- [ ] Throbbing
- [ ] Numbness
- [ ] Aching
- [ ] Shooting
- [ ] Burning
- [ ] Tingling
- [ ] Cramps
- [ ] Stifness
- [ ] Swelling
- [ ] Other:

4. How often do you have this pain? Is it constant or does it come and go?

5. Does it interfere with:

- [ ] Work
- [ ] Sleeping
- [ ] Daily Routine
- [ ] Recreation
- [ ] Exercise

6. Activities or movement that is painful to perform:

- [ ] Sitting
- [ ] Standing
- [ ] Walking
- [ ] Bending
- [ ] Lying Down

7. What treatments have you already received for your condition?

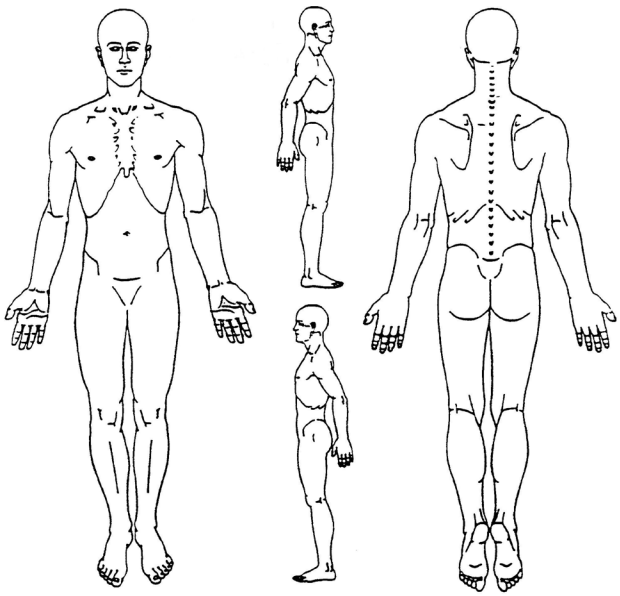
- [ ] Medication
- [ ] Physical Therapy
- [ ] Chiropractic
- [ ] Acupuncture
- [ ] Other

Notes:

Place an "X" on the drawing indicating the areas causing your pain and letter describing it.

A=Ache B=Burning S=Stabbing
N=Numbness P=Pins and Needless

Front **Back**



Pain Scale

Please check the number that best describes your pain.

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

None Little Medium Severe

Describe the cause of the illness: