Holistic Healing Center

Feel your best, faster!

PATIENT INFORMATION

Name: _____ Nickname:_____ Sex:_____

DOB:_____ Marital Status: **Married** **Single** **Divorced** **Widow** **Other** SSN:_____

Phone Number: Home_____ Cell_____ Email:_____

Home Address:_____

Emergency Contact:_____ Relationship:_____ Phone Number:_____

Primary Care/ Referring Physician:_____

Location:_____Phone Number:_____

How did you hear about our office?: _____

INSURANCE INFORMATION

(OR provide a copy of the front and back of your card)

Insurance Provider Name:_____ Address:_____

Insurance ID Number:_____ Insurance Group Number:_____

Name of Policy Holder:_____ Relation to Patient:_____

Secondary Insurance Provider:_____ Address:_____

Secondary Insurance ID Number:_____ Secondary Insurance GroupNumber:_____

ASSIGNMENT AND RELEASE

I, the undersigned, have coverage with _____
(Name of Insurance Provider)

Assign direct to The Holistic Healing Center, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Holistic Healing Center, LLC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that my insurance is a contract between me (or my employer) and my insurance company. The Holistic Healing Center, LLC is not a party to the contract. Our fees are generally considered to fall within the acceptable range by most insurance companies and therefore may cover up to the maximum allowance determined by each carrier. This does not apply to companies who reimburse based on an arbitrary "schedule of fees" which bears no relationship to the current standard of care in this area. I further understand that not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. If I am not sure if a particular service is covered I will verify this with my insurance company. The Holistic Healing Center, LLC recommends that all patients verify their own benefits before beginning treatment. The Holistic Healing Center, LLC wishes to emphasize that as medical care providers, our relationship is with you and not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. I understand and agree that regardless of my insurance status I am ultimately responsible for timely payment for services rendered.

Signature:_____ Date:_____

HIPAA AGREEMENT

By signing this form, I understand that: Protected health information may be disclosed or used for treatment, payment, or healthcare operations. More information on HIPAA laws, please visit our website at https://holistichealingcenternj.com/patient-center/

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on the phone number listed? YES NO

May we discuss your medical condition with any member of your family? YES NO
If **YES**, please name the members allowed:

Name:_____ Phone Number:_____

Name:_____ Phone Number:_____

This consent was signed by:(PRINT NAME) _____

Signature: _____ **Date:** _____

MEDICARE AUTHORIZATION *(If Applicable)*

I request that payment of authorized Medicare benefits be made on my behalf to The Holistic Healing Center, LLC for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature:_____ Date:_____

PATIENT MEDICAL HISTORY

Patient Name:_____Date:_____

Reason for today's visit:_____

Occupation:_____ Hobbies:_____

Have you seen a Physical Therapist or a Chiropractor in the last 12 months? *(circle one):* **YES** **NO**

Do you smoke? **YES** **NO** If so, how often:_____

Please list any allergies (food, fragrance, latex, medications, etc.):

_____ _____

_____ _____

Please list any medications you are currently taking (over the counter and prescription):

_____ _____

_____ _____

Are you currently taking any supplements and/or vitamins? If so, please list:

_____ _____

_____ _____

Is your sleep affected by what is bringing you in today?_____

Describe your sleep pattern:_____

Do you exercise? If so, how often?(*circle one):* **NONE** **1-3X A WEEK** **3-5X A WEEK** **5-7X A WEEK**

What activities are difficult due to your health issue(s)?_____

What activities or treatments help your health issue(s)?_____

Please list any surgeries that you have had and dates:

_____ Date:_____

_____ Date:_____

_____ Date:_____

Have you been diagnosed with any of the following? **Circle all that apply.**

Anemia	Hepatitis
Asthma	High Blood Pressure
Blood clot/thrombosis/DVT	High Cholesterol
Chemical dependency/alcoholism/drug use	Kidney Disease
Circulatory Issues	Multiple Sclerosis
Cancer	Parkinson's Disease
Depression	Rheumatoid Arthritis
Eczema or Psoriasis/Other skin conditions	Stroke/CVA/TIA
Heart/Cardiac Issues	Tuberculosis
Pacemaker	Epilepsy
Thyroid issues	Diabetes
Arthritis	Other:_____

For women: Are you currently pregnant?(*circle one):* **YES** **NO**

How far along?(*circle one)*: **1st Trimester** **2nd Trimester** **3rd Trimester**

At Holistic Healing Center, we offer additional holistic therapies. Which of the following services are you open to trying in our office *(circle all that apply)*:

Acupuncture **Naturopathic Physicians** **Medical Massage**

What are your goals of treatment? (i.e. I would like to be able to walk without pain, I'd like to lose weight, etc.)

_____

_____

_____

CONSENT TO TREAT

I have answered these questions to the best of my knowledge. I understand providing incorrect information can endanger my health. It is my responsibility to notify my provider of any change in my medical status, medications, or symptoms. I authorize the staff to perform the services that I need.

Signature:_____**Date**_____

Person completing if not patient:_____ **Relationship:**_____