

Morgan Hill Family Wellness

Dear New Patient,

Welcome to Morgan Hill Family Wellness. I look forward to getting to know you better and to start that process I will need you to fill out the following forms. It is easiest to print these forms out and fill them out by hand as they are not set up to be filled out on the computer.

1. *Registration Form* – please sign page 2
 2. *Fee Agreement* – sign at the bottom
 3. Health History Questionnaire
 4. Physician's List
 5. *Notice of Privacy Practices* – please sign page 2
- **The How to Contact Us page is to keep for *your* records**

Please fill these forms out in advance and bring them to your first appointment. If you have any questions, please contact us and we'll be happy to help you out.

After your first appointment, I'll be sending you an e-mail inviting you to our e-mail list. We only use this list to send relevant information related to our practice. You will be required to confirm that you would like to receive our e-mails in order to get on our list. We respect your time and inbox and will never send you spam.

Sincerely,

Robin Green, L.Ac.

Morgan Hill Family Wellness

OFFICE POLICY

- A. All fees for medical services are due at the time of each treatment. If you have insurance that covers acupuncture, we will be happy to e-bill your insurance as a courtesy to you. However, it is your responsibility to track your claims and contact your insurance company regarding any delay in payment.
- B. If you need to cancel an appointment, please give us a minimum of 24 hours notice or you may be charged a \$50 late cancellation/no show fee.**
- C. Herbal patent medicines are prescribed for you and you only. Do not give herbal formulas to anyone else.

Initials _____

FOR YOUR INFORMATION

- 1. Sometimes after receiving an acupuncture treatment you may feel a little bit light-headed. If that is the case, please sit down for a while in the waiting room. In a few minutes you will feel relaxed and clear-headed.
- 2. Occasionally you may get a small hematoma (a small dime sized bruise under the skin) after an acupuncture needle is removed. This is not a cause for concern – it will go away in a few days. Gentle pressure applied to the site will stop any bleeding that is occurring under the skin.
- 3. We use only sterile disposable needles that are used once on each patient.

Initials _____

INFORMED CONSENT

My signature authorizes Robin Green, L.Ac. of Morgan Hill Family Wellness to treat me (or the patient for whom I am legally responsible) with Acupuncture & Chinese Herbal Medicine within the licensure granted by the Medical Quality Assurance Board of the State of California and the California Acupuncture Board. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based on the facts known, is in my best interests. I intend for this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. I authorize the release of any medical or other information necessary for insurance claim processing.

Signature _____ Date _____
(Patient, parent or guardian)

Morgan Hill Family Wellness

How to Contact Us

The best way to contact us is to call our main number

(408) 852-9659

The line is automatically answered and will give you a list of options to choose from. **During normal business hours you will be able to connect directly to the office phone by dialing 0.** If we are with a patient or away from the phone, please leave us a message and we will call you back as soon as we are able.

During normal business hours, Robin's extension (ext 701) will also ring through to the office phone and if she is available she will be happy to assist you. Otherwise, you will be directed to her voicemail where you can leave a message for her. Tuesdays and Thursdays are Robin's days off to spend with her children. Please understand that she is not available on those days unless it is an emergency.

You can also contact us via e-mail at morganhillwellness@gmail.com Due to the high volume of e-mail we receive it may take us a few days to get back to you.

How to Schedule an Appointment

There are four ways to schedule an appointment with us.

1. In person or on the phone during our normal business hours by calling the main number & pressing 0
2. Through our website at <http://www.morganhillwellness.com/information-and-fees/book-your-appointment-online/>
3. Through our 24/7 appointment hotline (408) 852-9659 x 702. This is an off-site scheduling service that has access to our online schedule and can help with routine scheduling and appointment changes. However, if you have specific questions regarding treatment, billing or need an emergency appointment, they will not be able to help. During normal business hours call our main number and press 0 or afterhours you can leave a message for either Robin or Cristal. For emergencies, see below.
4. Send an e-mail to morganhillwellness@gmail.com

Emergencies & After Hours Situations

We understand that emergencies happen and after hours treatments may be required. Robin will do her best to be available to you in those situations. If you are in need of an emergency phone consultation or treatment, you may contact Robin directly calling the main number (408) 852-9659 x 706 where you will be transferred to her cell phone. Please understand that you will be charged a \$45 phone consultation fee. If as a result of the phone consultation an appointment is made, the phone consultation fee will be applied toward that visit. The fee for afterhours/emergency treatments is \$135 minimum.

Normal Business Hours

Mondays 9:00 – 6:30

Wednesdays 8:30 – 5:00

Fridays 8:00 – 11:00

Morgan Hill Family Wellness

FEES, INSURANCE, CASH & PAYMENT AGREEMENT FOR ACUPUNCTURE & ORIENTAL MEDICINE CARE

CANCELING OR CHANGING APPOINTMENTS:

We will set a specific course of treatment for you. A certain number of visits in a set amount of time are required to get results. If you need to change or cancel an appointment, be sure to make up the appointment within a week. If, for some reason, you need to cancel an appointment, please call ahead and let us know so that we may accommodate another patient at that time. **A no show without cancellation notice 24 hours prior to the scheduled appointment is subject to a \$35 cancellation fee.**

PAYMENT DUE AT TIME OF SERVICE

Payment is due at the time services are rendered. If you have insurance, we can provide a superbill for you to mail to your insurance company with their appropriate claim for. Your insurance company will reimburse you directly. We will be glad to provide you with whatever paperwork your insurance company needs to reimburse you. However, it is your responsibility to follow-up with your insurance company should there be any delay in payment to you.

ADVANCED PAYMENT ARRANGEMENTS

In cases where payment arrangements have been made with our office and your account becomes past due, we reserve the right to add a financial charge at an interest rate of 1.5% per month for every month that an account remains overdue, after 30 days.

FEES

The fees charged at this office are comparable to those charged by other specialists with similar qualifications in this geographic area. The fees for office services are payable at the time of the visit, except in certain cases where arrangements have been made with our office.

For your information, some of our fees are as follows:

| | |
|---|---|
| Initial Consultation + Treatment | \$100 |
| Acupuncture +1 Modality (60 Minute Session) Includes: acupuncture, electroacupuncture, moxabustion, Cupping, myofascial release, or herbal consultation | \$75 |
| Acupuncture only (45 Minute Session) Includes: Acupuncture & herbal medicine refills | \$60 |
| 30 Minute Pediatric Session (ages 13 and under) Includes: Pediatric Acupuncture, Non-needle acupuncture therapy, herbal medicine consultation | \$45 |
| House Call/ Emergency/After Hours Treatment One hour minimum + \$20 travel fee outside of Morgan Hill | \$135 per hour |
| Emergency Phone Consultation on Days off/Weekends * If this call results in scheduling an office visit, the phone consultation fee will be applied toward that visit. | \$45 |
| Acugraph Scan | \$15 |
| Report of Findings | \$15 |
| Herbal Formulas | Additional Charge Will be discussed before dispensing |

Patient Signature

Date

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PATIENT NAME _____ DATE _____

Health History Questionnaire

All information in this questionnaire will be a part of your medical record and is strictly confidential.

Please briefly describe your major complaint:

What are your goals for treatment:

What have you tried to help make this condition better?

Medical History: Please check all that apply

- | | |
|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergies to cosmetics |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis: What kind? |
| <input type="checkbox"/> Cancer: What kind? | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Mitral valve defect/prolapse |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Seizures or Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Lymph nodes removed | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Other | |

Injuries, Surgeries, Major Illnesses

Please provide details & dates of childhood or Adult injuries, surgeries or major illness

Please list any medications or supplements you are currently taking:

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Please Answer the Following Questions About your Diet

What kind of fruits do you eat?

of servings per day _____ During which meals/snacks do you eat them?

What kind of vegetables do you eat?

of servings per day _____ During which meals/snacks do you eat them?

Do you eat breakfast everyday? _____

How many major meals do you eat per day? _____

Do you your meals eat at regular times throughout the day? _____

Are you typically starving before you eat a meal? _____

Do you feel shaky or irritable if you've gone too long without eating? _____

How many snacks do you eat per day? _____ What time(s)? _____

Do you eat fast food? _____ How many times per week? _____

Do you dine out? _____ How many times per week? _____

Do you eat after 8 pm? _____ What do you typically eat? _____

Do you eat sugar/sweets on a daily basis? _____ How many times per day or week? _____

How many servings of bread, pasta, crackers, rice, do you eat per day? _____

How many servings of milk, yogurt, and/or cheese do you eat per day? _____

Do you eat salty foods regularly? _____

Do you have food cravings? _____ What do you crave?

Do you have food intolerances (ex. Lactose intolerance)?

How many glasses/cups do you drink each day of the following?

Water _____ Soda _____ Coffee _____ Tea _____ Wine _____ Beer _____

How many servings per day/week do you consume of?

Beef _____ Chicken _____ Fish _____ Tofu _____

Please Circle Where you fall on this scale: No Thirst 1 2 3 4 5 6 7 8 9 10 Always Thirsty?

Extremely Thirsty in afternoon or evening only ?

Do you prefer hot drinks or cold drinks?

PHYSICAL ACTIVITY

What kind of exercise do you engage in?

How often?

Please check the following symptoms that apply to you: x = minor xx = moderate xxx = severe

SPLEEN NETWORK

- | | |
|---|---|
| <input type="checkbox"/> Tender, sore muscles | <input type="checkbox"/> Lack of muscle tone or strength |
| <input type="checkbox"/> Difficult bowel movement | <input type="checkbox"/> Fluctuating appetite |
| <input type="checkbox"/> Slow digestion or Indigestion | <input type="checkbox"/> Lingering hunger after meals |
| <input type="checkbox"/> Frequent abdominal gas or bloating | <input type="checkbox"/> Craves sweets after meals |
| <input type="checkbox"/> Easily worried, repetitive & compulsive thinking | <input type="checkbox"/> Difficulty focusing, easily distracted |
| <input type="checkbox"/> Overwhelmed by details, upset by changes | <input type="checkbox"/> Tired, hard to get started |
| <input type="checkbox"/> Water retention, puffiness | <input type="checkbox"/> Heaviness of head or limbs |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Loose Stools |

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| HEART NETWORK | |
|---|---|
| <input type="checkbox"/> Anxiety or Dread | <input type="checkbox"/> Restless and excitable |
| <input type="checkbox"/> Easily confused or scattered | <input type="checkbox"/> Mood swings (laughs easily, cries easily) |
| <input type="checkbox"/> Insomnia when worried, nervous or excited | <input type="checkbox"/> Cravings for cool drinks |
| <input type="checkbox"/> Excitement, anxiety and fatigue cause light, restless sleep and vivid dreams or nightmares | <input type="checkbox"/> Cravings for hot, spicy foods |
| <input type="checkbox"/> Difficulty staying asleep, restless sleep | <input type="checkbox"/> Sores of mouth or tongue |
| <input type="checkbox"/> Easily overheat and perspire | <input type="checkbox"/> Blush easily |
| <input type="checkbox"/> Frequent urination or bowel movements when nervous | <input type="checkbox"/> Rapid heart beat or palpitations when nervous |
| LIVER SYSTEM | |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Blurred or unclear vision, blinking to clear vision |
| <input type="checkbox"/> Nervous, irritable, short tempered | <input type="checkbox"/> Easy chilling arms, hands, legs, feet |
| <input type="checkbox"/> Course brittle nails or hair | <input type="checkbox"/> Touchiness from heat, wind, noise or bright light |
| <input type="checkbox"/> Numbness or tingling of limbs when asleep or inactive | <input type="checkbox"/> Muscle cramps of pelvis, sides, hips, calves or feet |
| <input type="checkbox"/> tension in shoulders, neck, sacrum, hips, legs | <input type="checkbox"/> stitching pains around rib cage, groin or pelvis |
| <input type="checkbox"/> dry or hard stool, tension or cramping in colon | <input type="checkbox"/> high pitched or loud ringing in ears (tinnitus) |
| <input type="checkbox"/> dizzy, queasy, flushed or headache from hunger tension or anger | |
| LUNG NETWORK | |
| <input type="checkbox"/> Frequent lingering colds or coughs | <input type="checkbox"/> Colds easily go into chest |
| <input type="checkbox"/> Frequent throat clearing or laryngitis | <input type="checkbox"/> Runny or stuffy nose |
| <input type="checkbox"/> Morning attacks of coughing or sneezing | <input type="checkbox"/> Constant phlegm in chest or throat |
| <input type="checkbox"/> Shortness of breath, chest pain, wheezing from fatigue or exertion | <input type="checkbox"/> Dry nose or mouth |
| <input type="checkbox"/> Urge to urinate after laughing or coughing | <input type="checkbox"/> Skin rashes, eczema or hives |
| <input type="checkbox"/> Sensitive to cold, wind or dryness | <input type="checkbox"/> Stiffness of joints & muscles |
| <input type="checkbox"/> Respiratory Allergies | |
| <input type="checkbox"/> Allergy symptoms: | |
| | |

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| KIDNEY NETWORK | |
|---|---|
| <input type="checkbox"/> Puffiness around eyes | <input type="checkbox"/> Diminished libido |
| <input type="checkbox"/> Loss or thinning of hair | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Low back stiffness |
| <input type="checkbox"/> Weakness or soreness in hips, knees, ankles or feet | <input type="checkbox"/> Lack of stamina or endurance |
| <input type="checkbox"/> Needs a lot of sleep | <input type="checkbox"/> Diminished motivation and apathy |
| <input type="checkbox"/> Forgetfulness and mental dullness | <input type="checkbox"/> Puffiness or swelling of feet & ankles |
| <input type="checkbox"/> Weak vision | <input type="checkbox"/> Dull hearing, hearing loss |
| <input type="checkbox"/> Low buzzing or humming in ears (tinnitus) | <input type="checkbox"/> Sore throat upon waking or from fatigue |
| <input type="checkbox"/> Easily afraid or insecure | <input type="checkbox"/> Hair loss or premature graying |
| Please Check all that Apply | |
| WOMEN ONLY - OB/GYN | |
| <input type="checkbox"/> Are you still menstruating? Yes No | <input type="checkbox"/> Unpredictable menstrual cycle |
| <input type="checkbox"/> Are you taking birth control? What kind? | |
| Menstrual Flow (circle all that apply): prolonged heavy medium light none | |
| How many days do you bleed? | What color is the blood (circle all that apply): Light Red Red Dark Red Purple Brown Black |
| <input type="checkbox"/> Blood clots in menstrual flow | <input type="checkbox"/> Low back pain with period |
| <input type="checkbox"/> Cramps/painful periods | How many days does the pain last? |
| <input type="checkbox"/> Face breaks out before period | <input type="checkbox"/> Bleed or spot between periods |
| <input type="checkbox"/> Abnormal pap smear | <input type="checkbox"/> Cervical biopsy, operation, cauterization, conization |
| <input type="checkbox"/> Sexually transmitted disease | <input type="checkbox"/> Yeast infections on a regular basis |
| <input type="checkbox"/> Chronic vaginal discharge | <input type="checkbox"/> Sores on genitalia |
| <input type="checkbox"/> Breast tenderness before or during period | <input type="checkbox"/> Ovarian Cysts or Polycystic ovarian syndrome |
| <input type="checkbox"/> Pelvic inflammatory disease Were you treated for it? | |
| <input type="checkbox"/> Uterine fibroids or polyps | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Pelvic adhesions | <input type="checkbox"/> Pelvic abnormalities |
| <input type="checkbox"/> Infertility problems how long? | <input type="checkbox"/> Miscarriage # of times _____ |
| <input type="checkbox"/> How many children to you have? | <input type="checkbox"/> Perimenopause |
| <input type="checkbox"/> Hotflashes # per day | <input type="checkbox"/> Nightsweats |
| MEN ONLY | |
| <input type="checkbox"/> Do you usually get up at night to urinate? | <input type="checkbox"/> Blood in urine? |
| <input type="checkbox"/> Decreased force of urination | <input type="checkbox"/> Difficulty with ejaculation or erection |
| <input type="checkbox"/> Testicle pain or swelling | <input type="checkbox"/> Prostate/rectal exam was done in the last year |
| ANY ADDITIONAL HEALTH CONCERNS: | |
| | |
| | |
| | |
| | |

Morgan Hill Family Wellness

Physician's List

Primary Care Physician

Name/Office _____

Phone Number _____

Address _____

Specialists

(OB, Gastroenterologist, Psychiatrist, Counselor, etc)

Specialty/Seen for: _____

Name/Office _____

Phone Number _____

Address _____

Specialty/Seen for: _____

Name/Office _____

Phone Number _____

Address _____

Specialty/Seen for: _____

Name/Office _____

Phone Number _____

Address _____

Morgan Hill Family Wellness

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Morgan Hill Family Wellness we are committed to treating and using protected health information about you responsibly. This Notice of Privacy Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice is effective 7/23/07, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Information

Our office is permitted by federal privacy laws to make uses and disclosure 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.

Examples of Disclosures for Treatment, Payment, and Health Operations

Morgan Hill Family Wellness collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of our medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. *Treatment:* We may disclose your health information to a physician or other healthcare provider providing treatment to you, or who will provide services which we do not provide. We may also share information with a laboratory that performs a test.
2. *Payment:* A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
3. *Healthcare operations:* We may obtain services from business associates, such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. We may use or disclose your health information to provide you with appointment reminders via phone, e-mail or letter.
4. *Notification and communication with family:* We may disclose health information to a family member, or your personal representative or another person responsible for your care about your care, location, and general condition. Using our best judgment, we will only disclose health information that is directly relevant to the person's involvement in your care.
5. *Required by law:* We may also use or disclose your health information when we are required to do so by law. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products or reactions to medications.

When Morgan Hill Family Wellness May Not Use or Disclose Your Health Information

Most uses and disclosures that do not fall under treatment, payment, and healthcare operations will require your written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Your Health Information Rights

You have the right to:

- Restrict the disclosure of your protected health information by written request. The request for restriction may be denied if the information is required for treatment, payment of healthcare operations;
- Received confidential communications regarding your protected health information;
- Inspect and copy your protected health information with written request to our office using the form we provide upon request;
- Request that your protected health information be amended to correct incomplete or incorrect information (in writing);
- Receive an account of disclosures of your protected health information upon written request; and
- Obtain a paper copy of this Notice of Privacy Practices upon request.

Our Responsibilities

Morgan Hill Family Wellness ♦15585 Monterey Rd., Ste C ♦Morgan Hill, CA 95037♦(408) 852-9659

www.morganhillwellness.com

E-mail: morganhillwellness@gmail.com

Morgan Hill Family Wellness

Our office is required to:

- Maintain the privacy of your protected health information as required by law;
- Provide you with a notice as to 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;
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to make the new provisions effective for all protected health information we maintain. 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.

For More Information or to Report a Problem

If you have questions and would like additional information, please contact us at the following address or phone number:

15585 Monterey Rd. Ste C
Morgan Hill, CA 95037
(408) 852-9659

If you believe your privacy rights have been violated, you may file a written complaint with our office. You may also file a complaint by mailing it to the Secretary of Health and Human Services at the following address:

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services as a condition of receiving treatment from the office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Print Name _____ Date _____

Signature _____