WELCOME TO WHOLE HEALTH CENTER
CONTACT INFORMATION

First Name: ______________________ Last Name: ________________________

Address: ____

City: ____________________ State: _______ Zip: ________ DOB: _____________

Telephone – Preferred: ________________________ (circle: Home Cell Work)

Other: ____________________________ (circle: Home Cell Work)

Email Address: ____

By providing the above information, you consent to receive appointment reminders, health newsletters, and occasional promotions via email and/or text message (messaging and/or data fees may apply).

We will not sell or give your information to any other agency.

Primary Care Clinic/Doctor Name: _______________________________________

Primary Care Phone Number: ____

May we contact this provider regarding your treatment? YES___ NO___

Emergency Contact:

Name: ______________________________ Telephone: ____________________

Relationship: ____________________________________

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please tell the front desk.

How did you learn about us? (Please circle)

Friend or Family (name) ____

Physician (name) ____

Insurance Company ____________________________ Health Fair _________________________

WHC Website Newspaper Walk-in Internet Search Social Media

MISSION STATEMENT

Whole Health Center provides information, education, and access to complementary health services for people seeking wellness. Whole Health Center connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and is responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: ____________________________________ **Date**: __________________

Acupuncture Patient Information

First Name ______________________ Last Name ______________________ Date ______________

Gender (Please circle): M F Date of Birth ___________________ Age _________

Marital Status (Please circle): Single Married Partnered Separated Divorced

Place of Employment ______________________________ Occupation _________________________

Who referred you to us? ____

Chief Complaint: ____
How long? ______________________________ How often: ____________________________
What caused this (accident, lifestyle, drug, etc.)? ______________________________________
Describe the worst it can be: ____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other? ______
____
Get temporary relief? _______ Fixes problem? _________ Causes side effects? ____________
How does this affect your life? ____
Affect your family? __________________________ Affect your sleep? __________________
Affect your work? ____________________________ Affect your hobbies? ________________
What is your goal/plan if the problem continues 5/10/20 years? ___________________________

Complaint #2: ____
How long? ________________________________ How often: __________________________
What caused this (accident, lifestyle, drug, etc.)? ______________________________________
Describe the worst it can be: ____
What treatments have you tried (ice/heat/rest/over-the-counter/prescription meds), other?
____
Get temporary relief? _________ Fixes problem? _______ Causes side effects? ____________
How does this affect your life? ____
Affect your family? _________________________ Affect your sleep? ____________________
Affect your work? ___________________________ Affect your hobbies? _________________
What is your goal/plan if the problem continues 5/10/20 years? ___________________________

Other Complaints: ____

List all practitioners you've seen for the above problems:

____

____

Disclosure

I, ___________________________, hereby grant permission to the acupuncturists at Whole Health Center to discuss my health conditions with the physician(s) named above.

_______________________________ _____________________

Signature *Date*

Please bring any lab work or imaging results you've had in the last year to your next appointment!

On a scale of 1-10, rate your commitment to get rid of the problem(s) and feel better__________
Have you had acupuncture before? ___________
If yes, where/who ________________________
Any concerns or fears about the needles? ______
If yes, what? __________________________
What are your goals of your acupuncture visits?

1. ______________________________
2. ______________________________
3. ______________________________

MEDICAL CONDITIONS Please List conditions & surgeries you have had and year diagnosed.		**ALLERGIES** Medications, Seasonal, Environmental, Food.

MEDICATIONS – Please list all prescription medications you use. Include those which you may only use occasionally. Remember inhalers, eye drops and nose sprays. NOTE: If need more space, use page 4.

Prescription Name	Purpose	How Long	Dose	How Often	Last Dose

SYMPTOMS – **NOTE**: For each symptom you currently have, rate its severity from 1- 5 (5 being the worst). LEAVE BLANK IF NOT APPLICABLE.

LIVER / GALLBLADDER

_____ Irritability / Anger
_____ Depression / Stress
_____ Headaches / Migraines
_____ Visual Problems
_____ Red / Dry / Itchy Eyes
_____ Gall Stones
_____ Dizziness
_____ Blurred Vision
_____ Feeling of Lump in Throat
_____ Clenching of Teeth at Night
_____ Muscle Cramping / Twitching
_____ Tension
_____ Joints/Neck/Shoulder Pain/Tight
_____ Poor Circulation
_____ Soft / Brittle Nails
_____ Emotional Eater

KIDNEY / URINARY BLADDER

_____ Urinary Problems
_____ Bladder Infection
_____ Lack of Bladder Control
_____ Weakness / Pain in Lower Back
_____ Decrease Bone Density
_____ Feel Cold Easily
_____ Low Sex Drive
_____ Excess Sexual Desire
_____ Poor Memory
_____ Loss of Hair
_____ Hearing Problems
_____ Cavities
_____ Craving / Avoiding Salty Foods
_____ Fear
_____ Hot Flush / Night Sweating

HEART / SMALL INTESTINES

_____ Heart Palpitations
_____ Chest Pain
_____ Insomnia / Sleep Problems
_____ Easily Startled
_____ Restlessness / Agitation
_____ Vivid Dreams
_____ Lack of Joy in Life

LUNG / LARGE INTESTINE

_____ Dry Cough
_____ Cough with Sputum
_____ Nasal Discharge
_____ Post-Nasal Drip
_____ Sinus Infection / Congestion
_____ Itchy, Red or Painful Throat
_____ Dry Mouth / Throat / Nose
_____ Skin Rashes / Hives
_____ Snoring
_____ Grief / Sadness
_____ Shortness of Breath
_____ Allergies / Asthma
_____ Low Resistance to Colds or Flu
_____ Sneezing
_____ Mild Fever Comes & Goes
_____ Smoke Cigarettes

BODY TEMPERATURE

Please check all the apply:

_____ Cold entire body
_____ Cold extremities
_____ Hot all day
_____ Hot only in afternoon
_____ Hot only at night
_____ Normal

SPLEEN / STOMACH

_____ Heaviness Anywhere in Body
_____ Fatigue / Worse After Eating
_____ Hard to Get Up in the Morning
_____ Edema (Swelling)
_____ Muscles Feel Tired Often
_____ Easily Bruising & Bleeding
_____ Bad Breath
_____ Decreased / Increased Appetite
_____ Crave Sweets
_____ Hypoglycemia
_____ Difficulty Digesting Oily Foods
_____ Nausea / Vomiting
_____ Gas / Belching
_____ Insulin Sensitivity
_____ Hemorrhoids
_____ Constipation
_____ Diarrhea
_____ Abdominal Pain
_____ Indigestion / Heartburn
_____ Over-Thinking
_____ Tendency to Gain Weight
_____ Brain Foggy

ENERGY LEVEL – *Please circle:*

Low 1 2 3 4 5 6 7 8 9 10 High

PERSONAL MEDICAL & FAMILY HEALTH HISTORY

Please indicate those that are current health problems for yourself and your family members with a “**C**” under the appropriate person’s column. “**P**” should be used to indicate a past problem. Leave blank those that do not apply. If you require more space, use the reverse side of this form.

	You	Father	Mother	Spouse	Brother(s)		Sister(s)		Children		
Age											
AIDS / HIV											
Alcohol											
Anxiety											
Arthritis											
Asthma / Hay Fever / Allergy											
Back Trouble											
Bursitis											
Cancer											
Constipation											
Depression											
Diabetes											
Digestive Trouble											
Headaches											
Heart Trouble											
Hepatitis											
High Blood Pressure											
Immune Disorder											
Insomnia											
Kidney Trouble											
Liver Trouble											
Migraine											
Neck Pain											
Thyroid Disorder											
Tobacco											
Weight Problem											
Other Emotional Problems:_______________											
Other:___________________											

If any of the above family members are deceased, please list their age at death and cause.

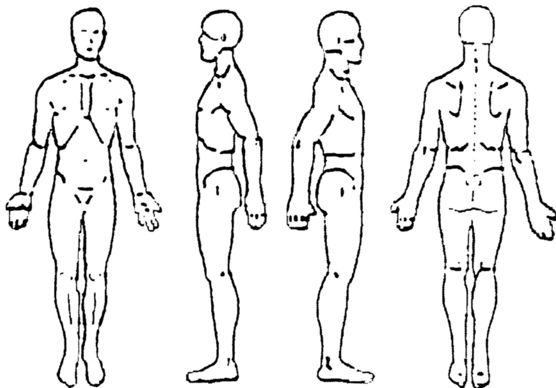
____

MUSCULOSKELETAL

☐ Muscle Cramps – Where? ☐ Muscle Pain / Rheumatism – Where? ☐ Arthritis – Where?

☐ Joint Swelling – Where? ☐ Tendonitis – Where? ☐ Bursitis – Where?

Please mark problem areas on diagram:



Describe Pain and Location

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:____________________

☐ Sharp ☐ Burning ☐ Aching

☐ Fixed ☐ Other:____________________

Women Only

Hysterectomy – Ovaries Removed? ☐ Yes ☐ No
Could You be Pregnant Now? ☐ Yes ☐ No

Number Of: ___ Pregnancies ___ Miscarriages
___ Births ___ Abortions

Post-menopausal Bleeding ☐ Yes ☐ No

When did your last period end? ______________

Number of days for monthly cycle? ______________

Number of days bleeding lasts? ______________

Describe Menstrual Flow:
☐ Heavy ☐ Moderate ☐ Light ☐ None

Color of Menstrual Flow:
☐ Dark ☐ Bright Red ☐ Slightly Reddish

Birth Control:
☐ None ☐ IUD ☐ Birth Control Pills
☐ Spermicides ☐ Barriers

Do You Suffer From:

☐ Cramping *(Mark as appropriate)*
- ☐ Severe ☐ Moderate
- ☐ Mild ☐ Before Period
- ☐ During Period ☐ After Period

☐ Clotting *(Mark as appropriate)*
- ☐ Bright in Color ☐ Dark in Color

☐ Bleeding Between Periods ☐ Infertility
☐ Pelvic Inflam. Disease ☐ Ovarian Cysts
☐ Endometriosis ☐ Hot Flashes
☐ Mastitis ☐ Breast Cysts
☐ Yeast Infection / Vaginitis / Other Discharge

☐ Premenstrual Syndrome *(Mark as appropriate)*
- ☐ Fluid Retention ☐ Cravings
- ☐ Fluctuating Emotions ☐ Irritability
- ☐ Tenderness in Breasts ☐ Depression
- ☐ Fatigue

Men Only

☐ Impotence ☐ Weak Erection
☐ Discharge from Penis ☐ Prostate Problems
☐ Testicular Pain or Lump ☐ Infertility
☐ Premature Ejaculation ☐ Low Sex Drive

Men and Women

Supplements

Name	Purpose	How Long

Diet & Lifestyle

What kinds (circle)	How much per day/week
Sugar: Candy	
Cookies / Baked goods	
Regular Soda / Diet Soda	
Chocolate	
Dairy: Milk	
Cheese	
Yogurt	
Ice-cream	
White Flour: Bread	
Pasta	
Coffee	
Alcohol	
Protein 50g per day?	
Eggs	
Dark green/vegetables	
Fruits	
Eat Breakfast?	
Eat fast food / on the run?	

Additional Notes

Please tell us about your exercise (regular, minimal, etc.):
____

Please list what you ate yesterday:
Breakfast__________________________________
Lunch_____________________________________
Dinner____________________________________
Snacks ____________________________________

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Women's Fertility History (If Applicable)

Name of your doctor / fertility specialist: Conceptions / CCRM / CRE / Kaiser / University Hospital / Other OBGYN doctor: ______________________________ Name of person who told you about us? ______________________________
Start date: ______________ month/year Current Month Treatment Plan ____________________ (IVF / IUI / Natural / Tests / Etc.)

1. Please list below all pregnancies and fertility treatments (including cancelled cycles):

Date	Natural, IUI IVF, Other	Medication Used	# of Mature Eggs / Follicles	Pregnancy Yes/No	If Miscarried , Indicate at which Week	Other Comments and Locations

2. Do you have any of these diagnoses?

	High FSH / AMH	Uterine Fibroids / Polyps	Endometriosis / Adhesions	PCOS	POF	Low Progesterone Level
Date						

Others:

3. Have you ever have any of these infertility tests or procedures?

	Laparoscope	HSG-Hysterosalpingography	Others:
Date			

4. Do you have any of these? If yes please list how many.

Pregnancies	Children	Miscarriages	Abortions	Ectopic	D&C	Abnormal Pap Smear	Others

5. Other:

Age at which menses began? ___________
Do you take birth control? ___________ If yes, how long? ___________
List name of birth control ______________________________________
Has your husband been checked out for fertility problems? ____
How long have you been trying to get pregnant? ____________
At Day 3______ at Day 10______ at ____________(month/year)
Do you get recurrent yeast infections? _________ How often? __________

Do you have to do a Clomid challenge test? _______
Do you ovulate on your own? ________
How can you tell you ovulate? ______________
Which day of your cycle ______ to ______
Have you done BBT testing? _______
Typically, how many days are there from one period to the next _____ to _____ days?
Today is which day of your cycle? ________

6. List any PMS symptoms before period:

	10 Days Before	1 Week Before	2-3 Days Before
Breast Tenderness			
Depression			
Fatigue			
Low Back Pain			
Face Break Out			
Other			

7. How is your period each day? Please check each day:

Symptoms (please check each day)	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6-7
Do you have Back Pain?						
Cramp (Light, Medium, Severe)						
Color (Light Red / Red / Dark Red / Brown)						
How Heavy is Flow (Light, Normal, Heavy)						
Is there Clotting?						
Is there Spotting?						

COLORADO MANDATORY DISCLOSURE STATEMENT

Acupuncture Associates
9075 Forsstrom Drive
Lone Tree, CO 80124
303 470-1995

Paul V. Murray, L.Ac., CNC
Wenying Lin, OMD, L.Ac.
Joong Yeon Kim, L.Ac.
Maggie Spresser, L.Ac., DACM
Valerie Lam, L.Ac.
Jenelle Girard, L.Ac.
Hannah Winner, L.Ac., DACM

Paul V. Murray received his degree at the Colorado School for Traditional Chinese Medicine (a credentialed 36-month program). He was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. He also studied 5-element acupuncture and earned a certificate in nutritional counseling. He studied Chinese medicine in China to earn additional experience. Paul is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). He is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2002. Paul is COO of ABORM, first fertility board in the U.S. He wrote and received a grant from the National Institutes of Health for a study on acupuncture and spinal cord injuries. Paul has not had any license, registration, or certification revoked or suspended.

Wenying Lin received her medical degree from Beijing University of Traditional Chinese Medicine in China (a credentialed 6-year program). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. Dr. Lin is certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). She is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture 1992. She is also a FABORM fellow to the American Board of Acupuncture and Oriental Medicine. Dr. Lin has not had any license, registration, or certification revoked or suspended.

Joong Yeon Kim received his degree from the Colorado School for Traditional Chinese Medicine (a credentialed 36-month program). He was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental medicine concepts. Joong Yeon is certified by the National Certification Commission for Acupuncture and Oriental Medicine. He is licensed to practice acupuncture in the state of Colorado and has been practicing acupuncture since 2009. Joong Yeon has also studied Korean Hand Acupuncture. He has not had any license, registration, or certification revoked or suspended.

Maggie Spresser earned her master's degree from AOMA Graduate School of Integrative Medicine in Austin, TX (a credentialed 4-year program consisting of 2,000 classroom hours and 1,008 clinical hours). She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Maggie is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice in the state of Colorado and has been practicing since 2018. Maggie is certified in Mei Zen facial rejuvenation and trained in Master Tung acupuncture. She has not had any license, registration, or certification revoked or suspended.

Valerie Lam received her master's degree from the Colorado School of Traditional Chinese Medicine (a credentialed 36-month, 3,030-hour program). She was trained in the recommendation and application of adjunctive therapies and herbal medicine as defined by traditional Oriental Medicine concepts. Valerie is also certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice in the state of Colorado and has been practicing since 2021. She has also studied Classical Chine se Medicine. She has not had any license, registration, or certification revoked or suspended.

Jenelle Girard earned her Master of Science degree in 2010 from Yo San University of Traditional Chinese Medicine in Los Angeles, CA. (a credentialed 4-year, 3400-hour program). She was trained in the recommendation and application of adjunctive therapies and herbal medicine as defined by traditional Oriental Medicine concepts. Jenelle is trained in Mei Zen cosmetic acupuncture so she can also perform facial rejuvenation needling. Jenelle is also certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice in the state of Colorado and has been practicing since 2010. She has not had any license, registration, or certification revoked or suspended.

Hannah Winner earned her Masters of Science in Oriental Medicine in 2017 from East West College of Natural Medicine in Sarasota, Florida (a credentialed 3 year, 4 month, 3048 hour program)..Dr. Winner continued her education at Pacific College of Health and Science and graduated in 2021 with her Doctorate of Acupuncture and Chinese Medicine. She was trained in the recommendation and application of adjunctive therapies and herbs as defined by traditional Oriental Medicine concepts. Hannah is certified by the National Certification Commission for Acupuncture and Oriental Medicine. She is licensed to practice in the state of Colorado and has been practicing since 2017. She has not had any license, registration, or certification revoked or suspended.

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Hannah Winner, L.Ac., DACM

This office complies with all rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning and sterilization of needles and the sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized; and they are disposed of in a manner consistent with OSHA and Colorado State regulations.

Cash at Time of Service Fee Schedule

Initial Acupuncture Evaluation and Treatment	$ 225*
Follow-up Acupuncture Treatment	$ 120
Prepaid Family Plans:	
5-visit package	$ 570
10-visit package	$ 1,080
20-visit package	$ 1,920

***Acupuncture packages expire 6 months from the date of purchase.**

*Coupons or other special discounts may apply.
Herbs are purchased separately.
Insurance is billed by code; payment varies by plan.

Patient's Rights

Each patient who visits this office is entitled to receive information about the methods of therapy, the techniques used, and an estimated duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies. The Colorado Department of Regulatory Agencies regulates the practice of acupuncture. If you have comments, questions, or complaints, contact the Acupuncturists Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone: 303 894-7800.

I have read and understand the above disclosure statement. I understand my rights and responsibilities as a patient.

Patient's Name (Please print): ____

____ ________________________
Signature of patient or legal guardian **Date**

Acupuncture Informed Consent

Acupuncture has been explained to me as a treatment consisting of the insertion of needles through the skin at specific points on the surface of the body (small amounts of electrical current may be applied to the needles). The purpose of acupuncture has been explained as the alleviation or cure of symptoms or disorders.

Acupuncture, acupressure, Moxa, cupping therapy, allergy elimination technique, nutritional or herbal counseling are considered experimental procedures and are not considered a substitute for Western Medicine. Therapies and advice offered shall not be construed by the client to be a diagnosis of treatment of any disease or injury. We recommend that you CONSULT YOUR PHYSICIAN for any serious conditions and receive at least two medical opinions. It is your right and responsibility for your own body.

I understand that complications may result from acupuncture treatment. Among these possible complications are: areas of anesthesia, fainting, weakness, nausea, hematoma, infection, pain and discomfort, pneumothorax, and aggravation of present symptoms. Being hungry, tired, or stressed can infrequently make the body more sensitive to the acupuncture treatment. Please tell your provider if you have any conditions that may inhibit blood clotting, such as hemophilia or coumadin use. Please use caution when walking with bare feet in the treatment room.

I further understand and agree to hold harmless, to indemnify and to protect against court action the individual therapist as well as the management and owners of this clinic, in the event of accidental injury on these premises.

Payment Practices

Acupuncture Associates gladly accepts health insurance, automobile insurance, and worker's compensation as payment. Insurance coverage depends upon your individual plan. Please call your insurance company to verify your acupuncture benefits. In the event your insurance does not cover acupuncture, discounted charges will be collected at the time of service.

Payment Agreement

I authorize Whole Health Center to release any information required to process this claim to any insurance company or attorney in this case. I also authorize my insurance company or medical provider to release my medical records to Whole Health Center. This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I hereby authorize my insurance benefits to be paid directly to Acupuncture Associates. I assume full responsibility for and agree to pay all costs, charges, and expenses of every kind and description for services furnished by Acupuncture Associates. I agree to pay charges and services not covered by any insurance or other third-party payer and/or not paid to Acupuncture Associates for any reason within a reasonable time (as determined by Acupuncture Associates). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

Cancellation Notice

Please be considerate of your appointment time. We make every effort to respect your time and see you promptly when you are scheduled. Please call if you cannot make your appointment or you are running late. Patients who consistently miss their appointments or fail to cancel 24 hours in advance may be charged for their missed appointments.

I have read and understand the above Informed Consent statement. I agree to the conditions set forth in this statement.

Patient's Name (Please print): ____

____ __________________________________

Signature of patient or legal guardian **Date**

Acupuncture
Privacy Practices

As your health care provider, we use your health information for evaluation and treatment; as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons:

1. Public health safety
2. Auditing purposes
3. Emergencies
4. At the request of your insurance carrier
5. When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. If, at any time, we change our policies regarding your medical information, you will be informed with a new "Privacy Practices" form to sign, as well as a new copy of "Notice of Privacy Practices."

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Whole Health Center, or you can file a written complaint with the U.S. Department of Health and Human Services. Whole Health Center is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

Whole Health Center reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of Whole Health Center and requesting a revised copy. Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

Consent

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations at Whole Health Center. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Whole Health Center for the purpose of analyzing, diagnosing, or providing treatment; as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Acupuncture Associates may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Whole Health Center is not required to agree to the restrictions that I may request. However, if Whole Health Center agrees to a restriction that I request, the restriction is binding on Whole Health Center. I have the right to revoke this Consent, in writing, at any time, except to the extent that Whole Health Center has taken action in reliance on this Consent.

My "protected health information" means health information, including any demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition that identifies me, or there is a reasonable basis to believe the information may identify me.

Patient's Name (Please print): ____

______________________________________ ______________________________

Signature of patient or legal guardian

Financial Policy for Patient Care Services

Whole Health Center wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy.

To help us help you, please:

1) Provide us with accurate and updated information on yourself and your insurance company.
2) Pay at the time of service for your entire balance.
3) Discuss your account balance only with the front office staff. It is important for practitioners to be allowed to provide patient care. If the front office staff cannot help you, do not hesitate to contact the office manager.

Insurance Patients:
We are happy to file insurance claims as a courtesy to you. It is your responsibility to see that the claims are paid. As stated by your insurance company: **"Verification of benefits is no guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. The balance due is your responsibility if we have not received payment from your insurance company within 60 days.

Whole Health Center sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible must be paid in full.

By signing this financial policy:

1) You are authorizing Whole Health Center, Acupuncture Associates, their providers, and employees to release any necessary information related to this visit and all future visits to your insurance company for the purpose of claim(s) payment. You are giving authorization to submit your claims without obtaining your signature on each and every claim submitted.
2) You are authorizing your insurance company and your medical provider to release your medical records to Whole Health Center and Acupuncture Associates for the purpose of claim(s) payment.
3) You are authorizing your insurance company to pay any medical benefits and all future claims for services provided by our office directly to Whole Health Center and/or Acupuncture Associates.
4) You are giving Whole Health Center and Acupuncture Associates the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
5) You agree that a photocopy of any document is as valid and effective as the original.

Whole Health Center, Acupuncture Associates, and its providers accept worker's compensation and auto accident insurance. We require that a lien signed by the patient and any attorneys is on file when applicable. Whole Health Center and its providers are willing to extend the expectation of payment within 60 days for worker's compensation and auto accident insurance when Med-Pay is not available.

If you prefer that we do not file insurance claims for you, you may pay the time-of-service discounted rate and send the claim to your insurance carrier. If you choose to submit your own claims, we will provide you with a super bill, but cannot assist you in filing your claims.

Self-Pay Patients:
If you do not have insurance or our services are not covered by your insurance company, you will be considered a "self-pay" patient. Family plans and discounts must be applied at the time of service and cannot be back-dated. If you have a financial hardship, an application for financing or a financial hardship discount must be completed before or at the time of service. It is important to Whole Health Center that you become well now, even if we need to work with your financial budget.

Cancellation Policy:
In order to provide you with the best care, please arrive 10 minutes prior to your appointment—late arrival may result in cancellation. We require 24 hours' notice of cancellation or you may be charged a fee. Please remember that failure to appear for your appointment prevents others from receiving care.

Finance Charges:
Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account over to a collections agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees. The responsibility for payment of medical services for you or your dependents is yours; due and payable at the time services are rendered unless financial arrangements have been made. You are responsible for all costs of collection, including attorney fees, collection fees of 25% of the principal balance, and court costs. Any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly).

Payment Options:
For your convenience, we are happy to keep your credit card on file and secured for payment of all services and products.

Please ask the front desk if you would like to apply for Care Credit financing and/or financial hardship.

Healthy People are Happy People

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Patient's Name (please print)

____ ____________________
Responsible Party or Authorized Person Signature Date

____ ____________________
Whole Health Center Signature Date

If you would like to keep your credit card on file in a secured location in our system, please tell the front desk.