HWC New Patient Form

Date _____

First Name _____ **Middle Initial** _____ **Last Name** _____

Address Line 1 _____

Address Line 2 _____

City _____ **State** _____ **Zip Code** _____

Home Phone (_____) _____ **Work Phone** (_____) _____

Cell Phone (_____) _____ **Email** _____

Date of Birth _____ **Sex:** ☐Male ☐Female

Social Security Number: _____ **Marital Status:** ☐Single ☐Married

Employment Status: ☐Employed ☐Unemployed ☐FT Student ☐PT Student ☐Other _____

How did you hear about our office?

☐Website ☐Internet Search ☐Physician Referral ☐Friend ☐Other _____

Emergency Contact

Contact Name _____ Relationship to Patient _____

Contact Home Phone (_____) _____ Cell Phone (_____) _____

Payment/Insurance Information:

Who is responsible for your bill? ☐Self-Pay ☐Health Insurance

Personal Health Insurance Carrier: _____ Insurance Card ID # _____

Policy Holder's Name: _____ Group # _____

Policy Holder's Date of Birth _____

Health History:

Please list your major health concerns in order of importance to you: _____

Check those that apply to your past medical history:

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune disorder
- ☐ Bleeding disorder
- ☐ Blood disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Hepatitis/Liver disease
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Joint replacement
- ☐ Kidney disorder
- ☐ Low blood pressure
- ☐ Lyme disease
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Rheumatoid arthritis
- ☐ Sciatica
- ☐ Seizures/Epilepsy
- ☐ Sinus infections
- ☐ Skin disease
- ☐ Stroke
- ☐ Thyroid disease

☐ Other _____

List any serious disease, injuries, surgeries, or hospitalizations you have had and the year they occurred:

Family History (List any family physical or mental illnesses and age of death):

Mother _____

Father _____

Grandparents _____

Siblings _____

Medications/Herbs/Supplements (List those you are currently taking):

Name _____ Reason _____ Duration/Dosage _____

Name _____ Reason _____ Duration/Dosage _____

Name _____ Reason _____ Duration/Dosage _____

Name _____ Reason _____ Duration/Dosage _____

Name _____ Reason _____ Duration/Dosage _____

Name _____ Reason _____ Duration/Dosage _____

HIPAA Privacy Practices

I acknowledge that I have received and /or have been given the opportunity to review this Office's Notice of HIPAA Privacy Practices for protected health information.

Print Patient's Name_____

Patient's Signature_____

Date_____

Consent to Treat a Minor: (Minor's Printed Name)_____

Guardian / Spouse's Signature Authorizing Care_____

Date_____

Financial Policies

Cancellation Policy

24 hours' notice is required to cancel an appointment. If 24 hours' notice is not given, you will be responsible for a $50 late fee. Insurance will not be billed for missed appointments.

Reasonable accommodations will be made in the case of emergency.

Payment Options

Cash, check, or credit/debit card are accepted. Payment in full is required at time of treatment.
There is a $40 fee for any bounced check(s).
In signing below, I acknowledge the above financial policies, and give my consent for payment of services and billing my insurance at this practice.

Print Patient's Name_____

Patient's Signature_____

Date_____

Consent to Treat a Minor: (Minor's Printed Name)_____

Guardian / Spouse's Signature Authorizing Care_____

Date_____

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments, other chiropractic procedures, acupuncture treatments and other procedures associated with the practice of Traditional Chinese Medicine, including various modes of therapy modalities on myself (or on the patient named below for whom I am legally responsible) by the licensed Doctor of Chiropractic/Licensed Acupuncturist of Huang Wellness Center or any practitioner, who now or in the future, works as a Doctor of Chiropractic/Licensed Acupuncturist.

I understand that methods of treatment may include but are not limited to chiropractic adjustments, acupuncture, moxibustion, cupping, electrical stimulation, and bodywork therapies such as Medical Massage and Tui Na (Chinese Medical Massage).

I also understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, and soreness. I have been informed that acupuncture is a safe method of treatment, but that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Rare and unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although this site uses sterile, disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

The herbs and nutritional supplements (from plant, animal, and mineral sources) which may be recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. Further, I wish to rely on the practitioner to exercise judgment during the procedure which the practitioner feels are in my best interests at the time, based upon the facts then known.

I will notify the acupuncturist who is caring for me if I am, or become pregnant.

I understand the clinical and administrative staff may review my medical records and lab reports and that portions of my records may be used for teaching or research purposes, however my name and identifying information will not be disclosed. Otherwise, all of my records will be kept confidential and will not be released to any part without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend 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.

To be completed by patient's representative, if necessary (e.g. if the patient is a minor or is physically or mentally incapacitated

Print Name of Patient	Print Name of Representative
Signature of Patient	Signature of Representative
Date Signed	Date Signed

Recommendation for Examination by a Physician

I, _____Ian Huang_____, recommend to you
(licensed acupuncturist)

_____ that you be examined by a
(patient)

physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

_____ _____
Patient Date

Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10).

_____ _____
Acupuncturist Date

COVID-19 Informed Consent to Treat

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (mark in all seven boxes provided)

1) I understand my treatment may create circumstances, such as discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. ☐

2) I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. ☐

3) I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. ☐

4) I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: ☐

Fever	Dry Cough	Sore Throat
Shortness of Breath	Runny Nose	Loss of Taste or Smell

5) I understand travel increases my risk fo contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. ☐

6) I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to your and the staff at your office to proceed with providing care. ☐

7) I have been offered a copy of this consent form. ☐

I KNOWINGLY AND WILLIINGLY CONSENT TO TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 REISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONESNT TO COVER THE NETIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND OFR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent/Guardian	Witness
Signature_____	Signature_____	Signature_____
Name_____	Name_____	Name Ian Huang
Date_____	Date_____	Date_____