Patient Registration **(PLEASE USE BLACK INK & PRINT CLEARLY!)**

Patient's Name:____
First Name MI Last Name

Date of Birth:__________________ __Male __ Female __Single __Married __Widowed __ Divorced __ Separated

Street Address :____

City/State/Zip Code:______________________________ **Home Phone w/Area Code:**____________________

Cell Phone w/Area Code:______________________ **Fax w/Area Code**:____________________

e-mail Address:______________________________ Can this be used for communicating with you? Yes__ No__

Spouse's Name:______________________________

Spouse's Employer:______________________________ **Spouse's Work Phone #:**____________________

Patient's Employer:______________________________ **Work Phone w/Area Code:**____________________

Responsible Party:______________________ **Relationship:** __Self __Spouse __Parent __Other:__________

If patient is a Minor, are parents __Married __Divorced Custodial Parent:______________________________

Custodial Parent's Home Phone w/Area Code:____________________ **Work Phone w/Area Code:**____________________

In case of emergency, contact (not living with you):______________________________

Phone Number w/Area Code:____________________ **Relationship to Patient:**____________________

Is this work-related? __Yes __No **If yes, date of injury?**____________________**Claim #:**____________________

Is this auto accident related? __Yes __No If yes, date of injury? ____________________ Claims#____________________

Insurance Company to be billed______________________________

Adjuster's Name & Phone #______________________________

Attorney's Name & Phone #______________________________

____

Referring Physician's Name & Phone Number:______________________________

<u>PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION</u>

Insurance Company # 1:______________________________ **Phone Number:**____________________

>><u>Primary Insured's Name</u>:______________________________ **>><u>Date of Birth</u>:**____________________

Policy #:____________________ **Group #:**____________________ **Relationship:**____________________

Address:____

Insurance Company # 2:______________________________ **Phone Number:**____________________

>><u>Primary Insured's Name</u>:______________________________ **>><u>Date of Birth</u>:**____________________

Policy #:____________________ **Group #:**____________________ **Relationship:**____________________

Address:____

- **I hereby authorize the payment of medical benefits to Rachel S. Strass, LAc, DOM for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier. I permit a copy of this authorization to be used in place of the original.**
- **I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.**
- **I hereby authorize Rachel S. Strass, LAc, DOM to release any medical information necessary to complete and process my insurance claims.**

>>____ ____________________
>>*Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

I authorize Rachel S. Strass, LAc, DOM to treat me and use my personal health information for healthcare operations.

>>____ ____________________
>>*Patient's Signature* (OR Parent if patient is a Minor) Date

Billing Policy & Acknowledgement of HIPAA Privacy Policy

The following sets forth the general billing policy of Rachel S. Strass, LAc, D.O.M. Please review this information and sign where indicated.

- I understand that it is my responsibility to provide the office of Rachel S. Strass, LAc, DOM, accurate billing information at the time of check in and to notify the provider of any changes in this information.
- I understand that it is my responsibility to know my specialist co-pay (which can be different than my Primary Care co-payment) and to pay it prior to services being rendered. I understand that this is a contractual agreement that I have with my health plan and that the provider also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.
- I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a $25 NSF fee. I further understand that to rectify my account, I will be required to pay with either cash, a money order, cashier's check, or credit card.
- I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and that I have a financial responsibility to pay these amounts. I understand that I will be provided with two (2) statements for any balance due after insurance payment. I further understand that if I have not made payment prior to the second statement being mailed, that the second statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest or legal expenses associated with the collection efforts.
- I understand that the provider will obtain the necessary prior authorizations prior to rendering treatment. I further understand that prior authorization is not a guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier.
- I have received a copy of the Notice of Privacy Practices as required by HIPAA from Rachel S. Strass, LAc, DOM, and understand my rights with regard to my personal health information disclosure.

My signature below confirms that I have read and understand these billing policies, privacy practices and my financial obligation as pertains to the health care provider Rachel S. Strass, LAc, DOM.

____ ________________________

Patient's Signature Date

____

Legal Guardian to Patient (if patient is minor or incapable of signing)

Notice of Privacy Practices
(FOR YOUR RECORDS)

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information, describe how health information about you may be used and disclosed, and how you can get access to your health information. The Notices are given to all individuals receiving care. Please review this information carefully.

Understanding your health record

A record is made each time you come to your practitioner for a treatment or consultation. Your symptoms, the practitioner's judgments, and a plan of services are recorded. This record forms the basis for planning your care and treatment/consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

Understanding your health information rights

Your health record is the physical property of your practitioner, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record, and to request that appropriate amendments be made to your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred; you may revoke any further authorizations to use or disclose your health information. Should your practitioner need to contact you, you have the right to request communication by alternate means or to alternate locations.

My responsibilities

As your practitioner, I am required to maintain the privacy of your health information and to provide you with this notice of my privacy practices. I'm required to follow the terms of this notice and to notify you if I am unable to grant your request to disclose or restrict disclosure of your health information to others. I reserve the right to change my practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, I agree not to use or disclose your health information without your consent.

TO RECEIVE ADDITIONAL INFORMATION OR REPORT A PROBLEM, you may contact me. If you believe your privacy rights have been violated, you have the right to file a complaint with me and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by myself.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building,
Washington, DC 20201
OCR Hotlines-Voice: 1-800-368-1019

Practices Regarding Disclosure of Client Health Information
(FOR YOUR RECORDS)

Your health information will be routinely used for treatment/consultation and payment, and your consent, or the opportunity to agree or object is not required in these instances:

- **Treatment/consultation** - Information I obtain will be entered in your record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. My own expectations and those of others involved in your care may also be recorded.
- **Payment** – Your record will be used to receive payment for services rendered. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies your, your diagnosis and/or practitioner's impressions, and procedures performed.

In addition, the following disclosures are required by law and do not require your consent:

- **Food and Drug Administration (FDA)** – I am required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.
- **Worker's Compensation** – I will release information to the extent authorized by law in matters of worker's compensation.
- **Public Health** – I am required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury or disability, or to comply with mandated reporting requirements for tracking birth and morbidity.
- **Law Enforcement** – As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) in response to a valid subpoena; (2) In the event that a business associate believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of this practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect or domestic violence.

It is my practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, I will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here.

- **Business Associates** – Some or all of your health information may be subject to disclosure through contracts for services to assist your practitioner in providing health care. To protect your health information, I require these Business Associates to follow the same standards held by myself through terms detailed in a written agreement.
- **Communications with Family** – Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.
- **Marketing** – I may send information to you about treatment alternatives and other health-related benefits that you may find useful.
- **Supplements** – Your demographic information may be submitted to the company that distributes the supplements you purchase here.

<u>Please Print Clearly</u>

Patient Fact Sheet Date: _____________

Full Name: ___________________________

Please list all medications, vitamins, and/or food supplements you are currently taking:

Medication/Vitamin/Supplement	Dosage	Purpose

What brings you here for treatment? ____

What are your goals for treatment? ____

Who referred you/how did you choose us? ____________________________________

QUESTIONNAIRE	**Yes**	**No**
1. Have you ever had acupuncture before?	☐	☐
2. Please list any diseases in your family history		
3. Do you have a history of:		
a) Fainting?	☐	☐

	Yes	No
b) Epilepsy or other seizures?	☐	☐
QUESTIONNAIRE (cont'd)	**Yes**	**No**
4. What medical procedures have you had? (list each procedure and its date)		
5. Is there a possibility that you are pregnant?	☐	☐
6. Are you HIV positive or do you have Hepatitis in any form? If yes, please specify:	☐	☐
7. Have you or are you experiencing symptoms in the following areas: **please describe**		
a) Respiration: breathing, cough, asthma, smoking?	☐	☐
b) Digestion: gas, belching, reflux?	☐	☐
c) Elimination: constipation, diarrhea?	☐	☐
d) Musculo-Skeletal: bone, joint, or muscular weakness/pain?	☐	☐
e) Nervous: visual, auditory, poor coordination or balance?	☐	☐
f) Circulatory: high blood pressure, heart problems?	☐	☐
g) Emotional: instability, schizophrenia, compulsive behavior, addiction?	☐	☐
h) Genito-urinary: menstrual, menopause, andropause, venereal disease, UTI?	☐	☐
8. Please list any allergies.		

Client Policies

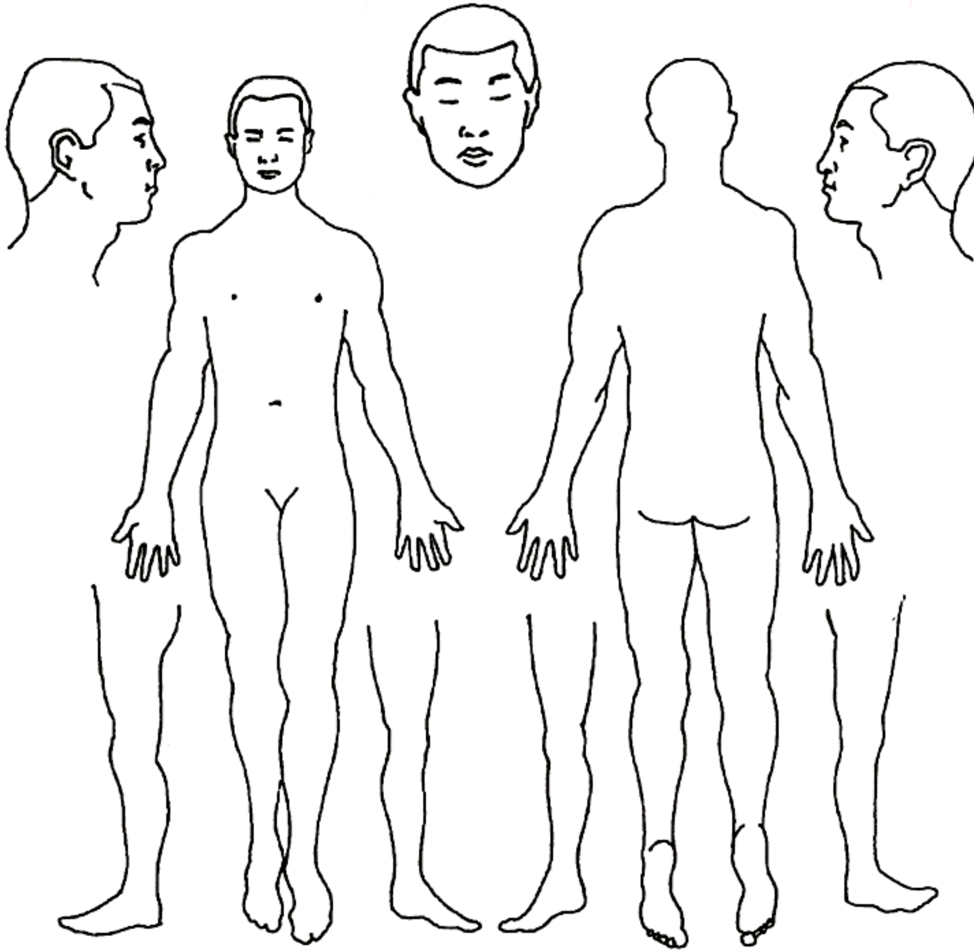
- **Please be ready to begin each session at your scheduled appointment time.** If you do arrive late, the session will not be extended. If you fail to show, you will be responsible for payment of the session.
- Standard sessions after initial consultation range from 45-60 minutes in length unless other arrangements are made.
- 24 hour notice of cancellation is required should you wish to cancel a session. **Failure to give required notice will result in a charge for the session.**

I have read, understood, and agree to honor the above policies.

Printed Name:		Dated:
Signature:		

Additional Info:

Please Mark Painful or Distressed Areas on the Chart Below:



NOTES:

Rachel Sara Strass
DOM, LAc, Dipl OM (NCCAOM)
National Board Certified
Licensed Acupuncturist

Spirit Point Healing (410) 570-2896 info@spiritpointhealing.com

Our Agreements About Appointments and Fees

Keeping our relationship working smoothly and respectfully is essential to me. So, barring highly unusual circumstances, I will not be more than 5-15 minutes late, if I am running late at all. Unless I have an emergency, I will not cancel our appointment with less than 24 hours notice. In return, I ask you to come to our appointment on time, and to agree that, in an emergency, you'll notify me if you are unable to keep our scheduled appointment. If an emergency occurs (something sudden and unexpected) that prevents you from keeping our appointment, I will not ask you to be financially responsible for the missed time.

In the normal course of events, if you need to change or cancel our appointment time, I ask you to give me at least 24 hours notice. **With less than 24 hours notice in a situation that is not an emergency, signing this form means you agree to compensate me for my lost time by paying me the full cost of an out-of-pocket treatment (currently $135 and subject to change without notice).** If I am able to fill the time with an appointment with another person, I will not ask you to be financially responsible for the time.

I ask you to pay in full at the time of each visit. **All credit/debit card transactions will have a 4% fee added to the total amount.** I will accept a copay for Blue Cross patients who are covered for acupuncture.

Signing this form creates a promise for mutual understanding and agreement about fees and appointments. These agreements are important for building an element of reliance from which we can begin to advance your health and well-being together.

I look forward to our ongoing partnership.

______________________________ ______________________________

Your Signature date Dr. Rachel S. Strass, DOM, LAc

Spirit Point Healing

Dr. Rachel S. Strass, DOM, LAc, Dipl OM (NCCAOM)
Acupuncture | Chinese Herbs
410-570-2896 | info@spiritpointhealing.com

RE: Permission to Correspond

I ______________________________ hereby give legal permission for Dr. Rachel S. Strass, DOM, LAc, Dipl OM (NCCAOM) to discuss the details of my treatments, including financial payment with the following people and/or healthcare providers:

Name	phone number	email address
1.		
2.		
3.		

Sincerely,

_________________________________ _____________________________________

Print Your Name Signature Date