MARK THOMPSON
Advancing Acutherapy
Acupuncture + Manual Therapy + Corrective Exercise

145 West 57th Street, 10th Floor
New York, New York 10019
Phone: 212-974-7240 Fax: 212-974-7228

485 Madison Avenue, 8th Floor
New York, New York 10022
Phone: 646-844-9670 Fax: 646-858-1858

Contact Information

Name: Date:

Address: Social Security #:

City: State: Zip:

Cell Phone: Home Phone:

Email:

Emergency Contact: Phone: Relationship:

Personal Information

Date of Birth: Height: Weight:

Occupation:

Referred By:

If not referred, how did you hear about us? (Internet, Facebook, Ads, etc.)

At Mark Thompson Acutherapy we strive to provide you with the best possible care, which includes consulting with your physician regarding your condition and progress.

Physician Information

Have you seen any of the following regarding your condition?

❑ Physiatrist ❑ Osteopath ❑ Orthopedist ❑ Chiropractor

If so, may we consult with them regarding your treatment? ❑ Yes ❑ No

Physician Name:

Office Address:

Office Phone: Email Address:

If not, may we consult your Primary Care Physician? ❑ Yes ❑ No

Primary Care Physician Name:

What are the main conditions you would like to be helped with?

When did it / they begin? Be specific.

To what extent does this interfere with your daily life (work, sleep, play, etc.)?

Have you been given a medical diagnosis? If so, please explain.

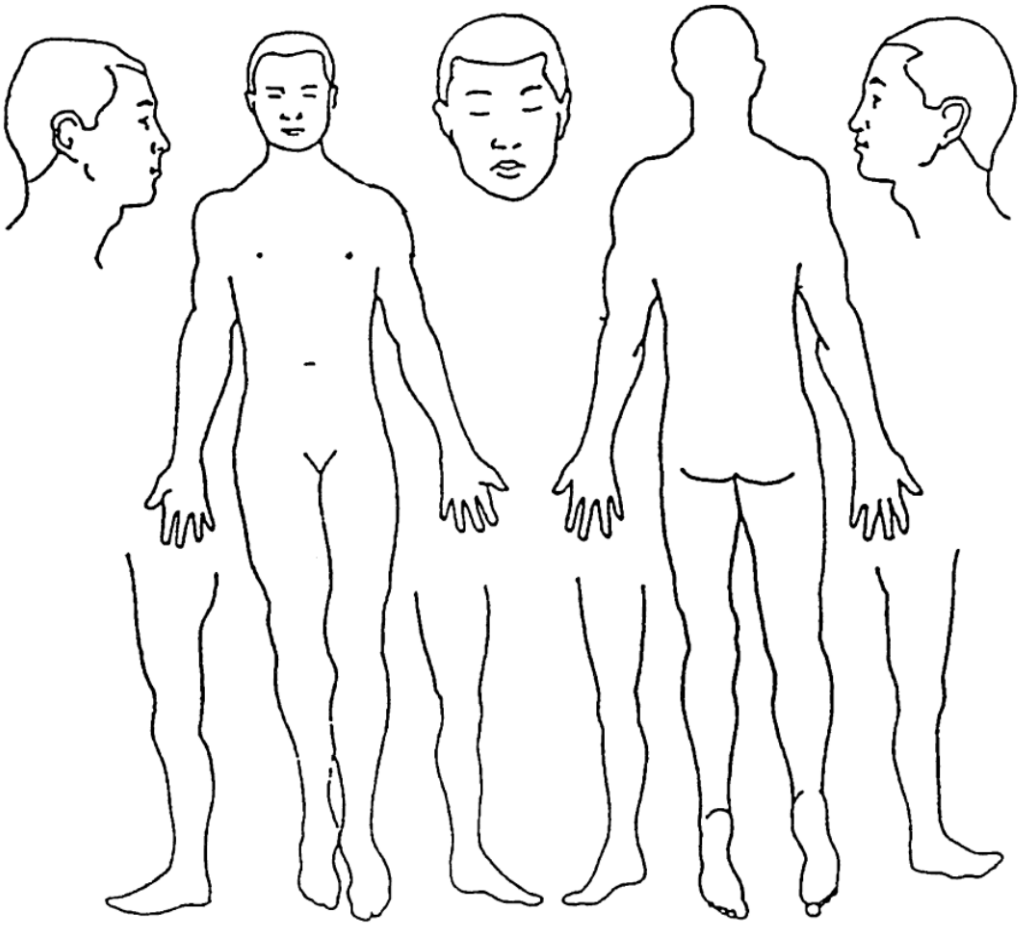
What kinds of treatment have you tried?

Please list any medications you are currently taking.

Please describe your program of physical fitness.

Please describe the levels of stress in your life. How does stress impact you and how do you deal with stress?

Mark any areas of pain on the diagrams below:



Family History	
Please note all major illnesses in your family (eg. diabetes, high blood pressure, cancer).	Relationship

Your Health History

Please describe any surgeries, injuries, accidents, or illness.	Approximate Age

Indicate any of the following you may be experiencing:

- ❑ Pain worse at night
- ❑ Night sweats
- ❑ History of cancer
- ❑ Change in bladder/bowel control or function
- ❑ Difficulty breathing
- ❑ Chest pain with exertion
- ❑ Lack of appetite
- ❑ Significant morning stiffness in back
- ❑ Unexplained fever/chills
- ❑ Unexplained weight loss
- ❑ Osteoporosis
- ❑ Changes in lower extremity function / sensation

Females Only

Date of last menstrual period:		How many days does it last?
Days in monthly cycle:	Age at first menstruation:	Age at menopause:
Have you ever taken birth control pills?		If yes, when and for how long?
Type of contraception now used:		

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PHYSICIAN CONSULTATION

All patients are advised under New York State Law to consult a physician regarding the condition or conditions for which they are seeking acupuncture treatment. In addition, patients are responsible for seeking the advice and treatment of a physician should their symptoms change for the worse, or should any new condition arise.

_____

Patient Signature Date

SERVICE AND FEE AGREEMENT

An initial thorough history and evaluation is followed by a full treatment. The plan of treatment will be determined at this time. Please allow 75 to 90 minutes.

Any appointments missed or canceled with less than 24-hours notice will incur the full service fee billed to your account. If we are billing your insurance company directly, please be advised that any fee related to deductibles, co-insurance, co-pays and claims denied will be billed to your account.

I hereby authorize payment of all medical benefits due under my insurance policy directly to Mark Thompson Acutherapy for all services rendered. I hereby agree to forward any and all monies received by me from my insurance carrier for rendered services to Mark Thompson Acutherapy. A photocopy of the authorization shall be considered as effective and as valid as the original contract.

I hereby authorize Mark Thompson Acutherapy, having treated me, to release to government agencies, insurance carriers, and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment.

Credit Card Type Credit Card Number

Expiration Date Billing Zip Code

I have read the above and agree to pay the fees listed at this time of service or via the credit card on file. I understand if I miss an appointment or cancel with less than 24-hours notice I will pay for that visit. I attest that I have read and understand this agreement.

Patient Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how the health data about you may be used and shared and how you can get access to this data.

I. How we may use and share health data about you:
   a. Treatment – To give you medical treatment or other types of health services
   b. Payment – To bill you or a third party for payment for services provided to you
   c. Health Care Operations – For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:
   a. To you
   b. As required by a federal, state, or local law
   c. If child abuse or neglect is suspected
   d. Public health risks (for public activities to prevent and control the spread of disease)
   e. Lawsuits and disputes (in response to a court or administrative order)
   f. Law enforcement (to help law enforcement officials respond to criminal activities)
   g. Coroners, medical examiners and funeral directors
   h. Organ or tissue donation facilities if you are an organ donor
   i. To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:
   a. Patient directories – You can decide what health data, if any, you want to be listed in patient directories
   b. Persons involved in your care or payment for your care – We may share your health data with your family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to health data we keep about you:
   a. Right to inspect your health record and to receive a copy upon request
   b. Right to amend information in your health record you believe is inaccurate or incomplete
   c. Right to know to whom we have disclosed your health information
   d. Right to ask for limits on the health information data we give out about you
   e. Right to receive communication from us about your health information in alternate ways
   f. Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge received the NOTICE OF PRIVACY PRACTICES of this office.

Signature of Patient or Patient's Representative Date