



119 West 57th Street, Suite 600
New York, NY 10019
Phone: 212-974-7240 Fax: 212-974-7228

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

Contact Information

Name: _____ Date: _____

Address: _____

City & State: _____ Zip Code: _____

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: _____

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.)?

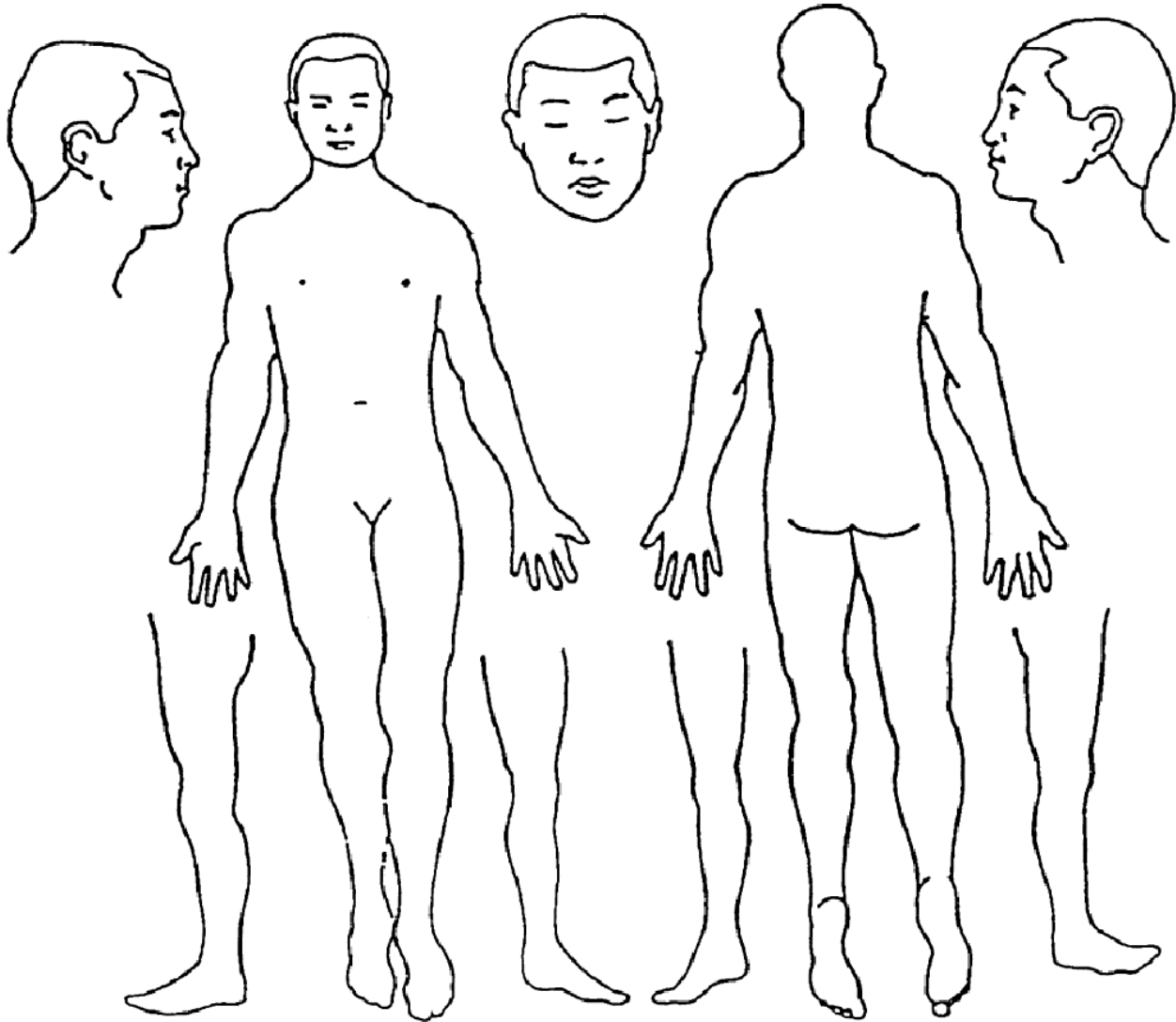
Have you been given a medical diagnosis? If so, please explain.

What kinds of treatment have you tried?

Please list any medications you are currently taking.

Please describe your program of physical fitness.

Mark any areas of pain on the diagrams below:



Family History

| Please note all major illnesses in your family (e.g. diabetes, high blood pressure, cancer). | Relationship |
|--|--------------|
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| | |

Your Health History

Check if any of these are in your health history:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV | <input type="checkbox"/> Cancer | <input type="checkbox"/> Vitamin B deficiency |
| <input type="checkbox"/> Hepatitis A, B, C | <input type="checkbox"/> Hashimoto's | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Underactive thyroid | <input type="checkbox"/> Other: |

| Please describe any surgeries, injuries, or accidents. | Approximate Age |
|--|-----------------|
| | |
| | |
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| | |
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| | |

Indicate any of the following you may be experiencing:

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

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 60 to 75 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 by insurance policy directly to Mark Thompson Acupuncture for all services rendered. I hereby agree to forward all monies received by me from my insurance carrier for rendered services to Mark Thompson Acupuncture. A photocopy of the authorization shall be considered as effective and as valid as the original contract.

I hereby authorize Mark Thompson Acupuncture, 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

Security Code

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 of services provided to you
 - c. Health Care Operations – for our own operations such a 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 healthcare
- 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 I received the NOTICE OF PRIVACY PRACTICES of this office.

Signature of Patient or Patient’s Representative

Date