Welcome to Impact Healing & Wellness Center!

The purpose these pages are to allow us to more completely serve you and for you to get the best results in the shortest amount of time. It is our experience that treatment is most effective for patients who adhere to the following policies:

1. Clothing

The acupuncture points for your condition will determine the areas of your body that need to be exposed. Please wear loose, comfortable clothing (e.g. pants that can be moved above the knee). If you need to change you may use our restroom facilities.

Patient Initials _____

2. Payment

We will expect you to honor your financial agreements you make with our office. If you find that you cannot fulfill the agreement you've made with us, please advise the office manager immediately so new agreements can be made. It is not our policy to bill patients (unless specific engagements have been made with office manager at the start of treatment). Our policy is that patients not maintain a personal balance due.

Patient Initials _____

3. Appointments

I. Please arrive 5 minutes before your designated time.

We have set up a specific course of treatment for you. A certain number of treatments in a set amount of time are required for us to get the results we both desire. Thus, we ask that you follow the guidelines below:

a. If you need to change the time of your appointment, plan to come another time on the same day.
b. If the same day is not possible, be sure to make up the missed appointment within 7 days.
c. If you miss/cancel/re-schedule your appointment without 24 hour notice you will be charged $40 for each appointment due before your next treatment.

Patient Initials _____

4. Dietary Suggestions, Liniments, Food Supplements, and Herbs

If applicable dietary suggestions should be followed, herbs and food supplements taken, and liniments used. Any problems you may have with these recommendations should be communicated to your acupuncturist.

Patient Initials _____

5. Sickness

Infections and illnesses, such as colds, flu, ear infections, and allergies are often times easily treated if addressed within the first 24 hours of onset. If not immediately addressed, these conditions can cause two possible outcomes: first, it may prolong your movement to stabilization, and second, it could be complicated by your current herbal formula. It is essential to let your acupuncturist know of such illnesses.

Patient Initials _____

6. Always Consult Your Doctor

An acupuncturist in the State of Colorado is not licensed to prescribe pharmaceutical drugs. If you want the clinic to treat a condition that is currently medicated we will be happy to do so, so as long as the condition has been diagnosed by your doctor and is not an emergency condition. If the patient decides they want to alter their pharmaceutical regime in any way, the patient must consult their doctor before doing so.

Patient Initials _____

7. Medical Release

I authorize the release of medical information to my insurance company(ies), including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company(ies) to pay directly to Impact Healing for those medical services.

Patient Initials _____

I have read the above and I understand these policies.

_____

Patient's Signature & Date

Patient Information:

First Name: _____ Middle Initial: _____ Last Name: _____

Nick Name: _____ Date of Birth: _____/_____/_____ Age:_____

Height: _____ Weight: _____ Preferred Gender: M F Other SSN: _____

Address: _____City: _____ State: _____ Zip Code:_____

Home Phone: _____ Cell: _____ Work:_____

Email: _____ Reminders: ❑ Text ❑ Phone ❑ Email

Occupation: _____ Employer: _____

Responsible Party:

Name of Responsible Party: _____ Date of Birth: _____/_____/_____

SSN: _____ Phone: _____ Relationship: _____

Insurance Information:

Primary Insurance: _____

Policy Number: _____

Group Number: _____

Secondary Insurance: _____

Policy Number: _____

Group Number: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Referral:

Doctor Name:_____ Phone: _____

How did you hear about us? _____

FINANCIAL AGREEMENT

I _____ (patient or guarantor) authorize Impact Healing/Dr. Sasha May to accept payments of medical benefits for services they provide. I understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid balances over 30 days past due.

Patient herby acknowledges and agrees that any account that becomes delinquent will be subject to collections services. Patient agrees to pay all costs and reasonable attorney fees for collections of all past due amounts owed plus interest thereon at 18% (eighteen percent) per annum on all such outstanding balances.

$20 service charge on all returned checks. Additional charges for cost of collection.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the clinic will be credited to my account upon receipt. However, I clearly understand that if I suspend or terminate any fees for professional services rendered to me they will be immediately due and payable/ I hereby authorize the Acupuncturist to treat my condition as he/she deems appropriate. I also agree that I am responsible for all bills incurred at Impact Healing.

PROVIDER NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY, IMPACT HEALING AND ALL OTHER HEALTH CARE PROVIDERS ARE REQUIRED TO INFORM YOU, THE PATIENTM HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOUSED.

As your Health Care Provider, we use your health information for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers via paper mail, fax, or other methods. We may use our 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

Patient's Rights

- The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.
- The patient may seek a second opinion from another healthcare professional or may terminate at any time.
- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Division of Registrations in the Department of Regulatory Agencies.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncturists registration office at: 1560 Broadway #1350, Denver, CO 80202. (303) 894-2440. If you have questions or concerns about your medical records, please contact the Office Manager at Impact Healing (303) 721-6123.

Impact Healing is required by law to protect your medical information and to provide this notice to you, along with your signature acknowledging your receipt of this information.

Signature of Patient/Guardian: _____ Date _____/_____/_____

Consent to Treat a Minor: _____ Date: _____/_____/_____

Health History Questionnaire

Important: Complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment. All information is strictly confidential.

Name of your primary physician: _____

Is there anything limiting you from care: ❑ YES ❑ NO _____

Other physicians/therapists seen for this condition: _____

Medications you are currently taking:

Medication Name	Dosage	Medication Name	Dosage
1.		4.	
2.		5.	
3.		6.	

Supplements

_____

_____

_____

Hospital Visits/Surgeries: _____(Procedure) _____ (Date of Surgery)

_____(Procedure) _____ (Date of Surgery)

_____(Procedure) _____ (Date of Surgery)

Major Complaint(s), in order of significance to you:

1. _____
2. _____
3. _____
4. _____
5. _____