PATIENT INFORMATION

Name

Street

City, State, and Zip

Male □ Female □

Date of Birth

Cell Phone

Other Phone (please specify)

Email

Occupation

Employer Name

Employer Address

Contact in case of emergency:

Name

Relationship to you

Phone

How would you prefer to be contacted for appointment reminders? email / phone

How did you hear about Balanced Health? (*if referred, please tell us by whom*)

I understand that Balanced Health Management, Inc. has a 24-hour cancellation policy. If I do not cancel my appointment by phone within 24 hours, I will be charged a $50.00 No Show fee.

Signature and date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Balanced Health is very concerned with protecting your privacy. While the law requires us to give you a copy of this disclosure, please understand that we always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health conditions.
- We may have to disclosure your health information and billing records to another party if they are potentially responsible for the payment of your treatment and services.
- We may have to disclosure your health information and billing records to another party if they are potentially responsible for the payment of your treatment and services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Balanced Health has a more detailed notice on file that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call at any time for a copy of our privacy notices.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment.

YOUR RIGHT TO REVOKE YOUR AUTHORIZATION

You may revoke your consent to us at any time; however, your revocation must in writing. We will not be able to honor revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read this notice and agree to its terms. I am also acknowledging that I have received a copy of this notice.

____ ____________________

Signature of Patient or Authorized Personal Representative Date

____

Printed Name

Balanced Health Management, Inc. – 30 Chauncy Street – Boston, MA 02111
617-542-8500
www.lifeneedsbalance.com

BALANCED HEALTH
integrating mindbody wellness

Patient Name ____________________ Date

HEALTH QUESTIONNAIRE
Restoration Treatment

Have you ever been treated by Acupuncture or Oriental Medicine before? Yes No

How is your energy level today? Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest

Occupational Stress (chemical, physical, psychological, etc.): ______________________________

____

Are you on a special diet? _______ If yes, describe: ____________________________________

Do you currently have digestive issues? ____

How much sleep do you get each night? ________________

Do you have a regular exercise program? _______ If yes, describe: _________________________

How much water do you drink daily? ____________________

How many caffeinated drinks do you drink per week (coffee, tea, soda)? ____________________

Do you smoke? ___________ If yes, how many cigarettes per day? _____________

Allergies (food, drug, seasonal, environmental): ____

Are you on any medication? If yes, please list them.

____

____

Is there any chance that you are pregnant? ________________

Circle any you have had in the past:

Bleeding Tendency	AIDS/HIV	Cancer	Diabetes	High Blood Pressure
Heart Disease	Lung Disorder	Kidney Disorder	Liver Disorder	
Digestive Disorder	Seizure	Stroke	Sexually Transmitted Disease	

Other: ____

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