Patient Information :: Intake Form :: Healing Waters Clinic

Confidential-Please Print Clearly

Massage clients fill in top of form only!

Name_____ Date_____.

Phone: Home_____Work_____Pager/Cell_____

Local Address_____ City_____

State_____ Zip Code_____

2nd Address (Out of State)_____City_____

State_____ Zip Code_____

Date of Birth_____Age_____ M_____ F_____ Marital Status_____

No. of children _____ Occupation_____

Are you pregnant?_____Which trimester_____Due date_____

Name of attending physician_____

Other doctors (include chiropractors, specialists, etc.)_____

_____

Who is responsible for this account?_____Do you have a lawyer?_____

Referred by_____

Check any that apply–how did you find us? Internet_____ Drive By_____ Advertisement_____

Your e-mail_____ Are you on Facebook?_____

Pain Relief, Herb, Nutrition clients fill out the rest of form.

Reasons for your visit to our office (you may check off more than one reason): Pain Relief_____

Stress Reduction_____Wellness Care_____ Health Education_____Pregnancy Massage_____

Rehabilitation from trauma_____Personal Growth_____Psychotherapeutic Support_____

Adjunctive or Complementary care for such medical conditions as cancer, MS, Parkinson's, etc._____

Postural, Structural or Constitutional Assessment_____ Children & Infants_____Sports Massage_____

Weight Loss & Management_____Energy Healing_____Detoxification & Cleansing_____Herbs_____

TMJ & Scoliosis_____Other_____

Present Symptoms: What is your major complaint? _____

_____

_____

On the next page you can list other symptoms. If you had a recent accident what was the Date of Injury?_____

Minor Complaints: Other areas of pain or concern _____

_____

_____

Do you have a medical diagnosis? List all conditions:_____

_____

When did you first notice major complaint?_____

When did you first notice other areas of pain or concern?_____

_____

What activities aggravate the condition?_____

_____

Is this condition getting progressively worse? Yes_____ No_____ Constant or Same_____ Comes and Goes_____

Is this condition interfering with your: Work____ Sleep____ Daily Routine_____

Have you received medical treatment for this condition?_____

_____

_____

Are you presently taking medications?_____What kind_____

_____

_____

If you have more than one doctor, are all your doctors aware of the amount and types of medications you

are taking?_____

Are you presently working with a psychotherapist, psychiatrist or psychologist?_____

Do you take birth control pills or hormones?_____

Have you ever had any operations? Yes_____ No_____ Describe Briefly_____

_____

Broken Bones?_____

Do you have Scar Tissue?_____

Have you ever been in an accident? Yes_____ No_____ More than one? How many?_____

Describe accidents briefly_____

_____

Do you have allergies? Yes_____ No_____ Describe Briefly_____

_____

Are you wearing: Heel lifts_____ Orthotics_____ Inner soles_____ How long?_____

Have you had recent or past dental stress or TMJ (jaw) pain?_____

_____

Menstrual cycle: Normal_____ Abnormal_____ Excessive_____ Light_____

Other_____

Bowel movements: Daily? Yes____ How many times_____ No_____

If not daily, how often?_____

Have you had a recent life crisis or stress?_____

_____

Have you ever been to a chiropractor, osteopath or massage therapist before?_____

_____

Have you ever been to an acupuncturist, nutritionist, herbalist, naturopath or other natural healer?

_____

Do you take vitamins or herbs?_____ List a few_____

_____

Do you drink: Coffee_____ Tea_____ Sodas_____Alcohol_____Water_____Eat Sugar_____ Smoke_____

Before you finish are there any other medical conditions that you might have forgotten to list like high blood pressure, diabetes, heart conditions, etc._____

List two things you like doing or are thankful for in your life_____

_____

Signature_____Date_____

The rest of this page may be used to add anything you would like us to know.

Laurence Layne, LMT, CNMT, CH
Healing Waters Clinic & Herb Shop
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St. Augustine, Florida 32084
904-826-1965

Notice of Privacy Practices (HIPAA form)

The privacy of your medical information is important to us. We create a record of the care and services you receive at our clinic. Any other personal information you disclose to us is also confidential.

You have a right to a copy of our Notice of Privacy Practices. We reserve the right to revise our Notice of Privacy Practices at any time. and a revised copy is available at our office.

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided on the letterhead above.

For Treatment: We may use health and medical information about you to provide you with natural healing treatment or services. We may disclose information about you to doctors, nurses, technicians, or other health practitioners to assist them in treating you. As an example, your doctor may call us or we may write a report to your doctor.

Communication: In serving you, we may have to contact your home by phone, mail, or Internet to confirm appointments, or discuss your care. We will not leave personal information on your message machine.

Billing: We may have to send treatment notes (SOAP notes) to insurance companies. They may send you copies of bills with medical information.

Legal: We may have to release office notes to lawyers if you are involved in a legal case.

Governmental Agency: Under certain circumstances we may have to disclose information to a governmental agency, law enforcement, or to a court or administrative body through subpoena.

We are giving you this notice because it is required by law. We have always had strict confidentiality practices at our clinic to ensure our patients privacy. If you have any questions about this Notice of Privacy Practices please ask us. By signing this form you are giving your consent for us to use your medical information in your treatments.

_____
Signature of Patient or Legal Guardian

_____
Patient's Name–Please Print

_____
Guardian's Name–Please Print

Date_____

Insurance Information
Confidential

Patient's Name_____

Patient's Social Security number_____Date of Injury_____

Insurance Company_____Phone number_____

Name of Insured_____Policy Number_____

Group number or other numbers_____

Adjuster_____Adjuster's phone number_____

Other_____

Insurance :: Informed Consent

Insurance is billed as a courtesy for our clients. We employ an insurance billing agency to submit our claims to the insurance company.

The average insurance bill for the average visit for therapy is $125.00. _____

The average cash payment per visit for a patient is $75.00, but sometimes higher. _____

This is because we have to use billing codes instead of fees per service or amount of time.

If the client prefers they may pay our standard fees for therapy by cash or credit card. We will give the client a receipt that they can turn into the insurance company. We reserve the right to have a sliding scale for clients of differing socioeconomic backgrounds. We reserve the right to offer cash discounts or issue discount coupons. We reserve the right to offer services on a donation basis for those in need or to donate our services to charitable events.

You can read a more in depth version of this Insurance Informed Consent by downloading it from out web site, or we can print it for you at our office. (www.healingwatersclinic.com/patientinfo.html)

<u>Your responsibility</u>:

You the patient are responsible for all bills and fees that result from treatment regardless of whether the insurance company pays or not. _____

The patient is legally responsible for any bills generated during treatment and handled by their lawyer including PIP (car accidents) and Letters of Protection. While there may be negotiation for reduction of bills with the patient's lawyer after a settlement, the patient is legally responsible for paying all bills.

If insurance checks are mailed to the patient's home, they must be turned over to us, the provider, or returned to the Insurance company. If the patient, a patient's family member, or an acquaintance attempts to keep money from Insurance payments by cashing checks we will consider such actions fraud and notify the Insurance company and turn the client over to appropriate law enforcement authorities. If the checks are stolen and cashed or "forged," or any other situation arises where money goes missing, the patient is still required to pay their bills. If the patient does not pay their bills, they can be turned over to a collection agency or taken to court.

We encourage the client to review Explanations of Benefits (EOBs) that are mailed to them from the insurance company. This will inform you as to what your insurance company is being billed by our insurance billing service. We will be glad to discuss and explain any charges.

I have read and understand this Informed Consent thoroughly.

Signature _____ Date _____

Herbal Healing :: Informed Consent

Herbal healing is the philosophy, art, and science of promoting health and wellness through the use of plants and natural remedies. Herbs can also play a role in the prevention and treatment of illness as supplements.

• The philosophy of herbal healing is based on the idea that there is a vital natural force that flows through the body that can be enhanced by the use of herbs. An herbalist is not a doctor and cannot diagnose disease or prescribe drugs.

• The art of the herbalist is to treat each person as an individual irrespective of the disease or condition they have and to stimulate their innate healing power through the use of herbs, diet and lifestyle.

• Finally, the science of herbalism is the judicious use of research to verify time-tested, traditional methods of herbal healing rather than an attempt to use herbs like drugs.

Our services include herbal sales, research, public education and consultations. A consultation is a time of personal one-on-one education about herbal therapies. Family members may also be present during this time.

Assessment by an herbalist may include asking questions, taking a health history, taking the pulse, looking at the tongue or eyes, palpation of the tissues and structures of the body, muscle testing and other wholistic methods. Treatment is really patient education is which a range of potential herbs, foods and lifestyle changes are discussed with the client. The various ideas and methods of herbal healing we use are drawn from a synthesis of world systems including the Chinese, the Native American, the East Indian (Ayurvedic), the European, the American (Physiomedicalism), and folk healing traditions.

Laurence Layne has completed a professional course of training in herbal healing of over 600 hours and is a certified herbalist. He has also had extensive life experience in vegetarianism, the macrobiotic diet and natural healing. He has worked with thousands of individuals in his role as an herbalist.

Laurence Layne is a member of the American Herbalists Guild and the American Botanical Council. The former group is a professional organization for herbalists, the latter group a research organization. The American Herbalists Guild has grievance process in place for client redress if the client feels that he or she has been mistreated or harmed or there was negligence on the part of the practitioner. This information is available on request.

The client is not required to purchase herbal products and remedies from our store. We make recommendations. Most of the time we carry what we recommend but often send people to other stores for items we do not carry.

The client by receiving an herbal consultation is taking a greater part in their health maintenance and is not a passive recipient of a treatment. This helps the client have a deeper understanding of the health process.

I have read, understand and agree with the above:

Signature_____

Print Name_____

Date _____