Maya Whole Health Studio

GENERAL INFORMATION

Name _____ Today's Date _____

Date of Birth _____ (Please check one) Male _____ Female _____

Address:_____ City _____ State _____ Zip_____

Phone (1) _____ (2) _____ E-mail _____

Emergency Contact Name: _____ Phone _____

Occupation_____Employer_____

How did you find Maya Whole Health Studio? _____

INSURANCE INFORMATION *Please fill out whichever portion(s) apply*

Prescription from a physician is required for massage services to be billed by Maya Whole Health Studio.
Prescription Provided? Please circle: YES NO

Health/Medical

Insurance Company _____

ID# _____ Group # _____

Name of Primary Insured _____Date of Birth _____

Referring Practitioner (if applicable) _____

Auto Accident (PIP) or Labor and Industries (L&I) Claim

Date of Injury _____ Claim # _____

Insurance Company _____Phone _____

Address of Company _____

Name of Claim Adjuster _____

Referring Physician (if applicable) _____

Notice: Upon your request, Maya Whole Health Studio provides courtesy billing to your insurance provider for your services. If for any reason, benefits are denied or delayed for services that have been provided, you will be billed for the balance on the account. We thank you for your cooperation and understanding.

1322 Lake Washington Blvd N Suite 3 Renton, WA 98056
Direct 425.271.0200 :: Fax 425..206.309.3383 :: www.mayawholehealth.com

Maya Whole Health Studio

EAM/Acupuncture Intake

Name: _____ Date: _____

Current Conditions: (check all that apply):

☐ Bleeding disorder ☐ Pace Maker ☐ Blood Thinning Medication ☐Pregnancy weeks _____

What is the primary health concern for which you are seeking treatment today? _____

_____

_____

How long has this been a concern for you? _____

Have you been given a diagnosis for this?: Yes___ No___ If so, what? _____

Have you tried any other strategies to address this concern? _____

Please note the severity of your problem:

No Problem |_____| Worst Imaginable

Current Health Factor

Marital status (*circle one*): Married Single Divorced

Do you have children in your home? Yes No Ages? _____

Do you get regular physical exercise? Yes No Frequency and Type:_____

Are you on a restricted diet now or have you been in past 3 months? Yes No

Please describe your typical daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Do you consume alcoholic beverages? Yes No If so, how often? _____ drinks/wk Type:_____

Do you partake in the recreational use of pharmaceuticals or herbal medicinal plants? Yes No

Do you smoke cigarettes, or other tobacco products? Yes No How often? _____

Do you drink caffeinated coffee, tea, or soft drinks? Yes No How often? _____

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Client Health History Information

Name: _____ Date: _____

General information

Please list any medications or supplements that you regularly use or have used in past months (including any that can thin blood, such as Coumadin, ibuprofen, garlic capsules, Vitamin C)

_____

_____

_____

_____

Please list any significant trauma, injuries, surgeries, or significant dental work, with approximate dates:

_____

_____

_____

_____

_____

Please check all that apply currently or in past, and circle those that are current issues.

€ Pregnant: weeks ____
€ Pacemaker
€ Bone or Joint Issues
€ Arthritis/ Gout
€ Lupus
€ Bleeding Disorder/Clots
€ Prosthetics
€ Tendonitis/ Bursitis
€ TMJ
€ Spinal concerns
€ Sprains/Strains
€ Varicose veins
€ High/ Low Blood Pressure
€ Irritable bowel syndrome
€ Breathing difficulty/Asthma
€ Heart Conditions
€ Lymphedema
€ Vertigo
€ Ulcers
€ Emphysema

€ Allergies specify: _____
€ Sinus Condition
€ Numbness/Tingling
€ Multiple Sclerosis
€ Rashes
€ Ovarian/Menstrual problems
€ Bladder kidney Ailment
€ Cancer _____
€ Chronic fatigue
€ Sleep disorders
€ Headaches/ Migraines
€ Contact lenses (hard or soft)
€ HIV/AIDS
€ Human PapilloVirus
€ Seizures
€ Shingles
€ Pinched Nerve
€ Fibromyalgia
€ Athletes Foot
€ Prostate Condition
€ Menopause
€ Chronic Pain
€ Depression
€ Stress/Anxiety
€ Diabetes
€ Hepatitis
€ Thyroid Disease
€ Rheumatic Fever
€ Other Significant Illness/Trauma:

_____

_____

_____

_____

_____

_____

Family History (immediate family, within two generations):

€ Diabetes
€ Cancer
€ Thyroid Disease
€ Heart Disease
€ High Blood Pressure
€ Stroke

I have completed this form to the best of my knowledge.I understand that all of the information provided is for use by Maya Whole Health Studio practitioners to support the improvement and/or maintenance of my health. I understand that this information will be made available to all Maya Whole Health practitioners who are engaged to provide services for me in efforts to improve and maintain my health.

Name _____ Date _____

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Health Care Waiver & Payment Agreement Policy

24 hour notice is required to cancel an appointment with no financial penalty

I understand that I am fully responsible for the payment of fees associated with services I receive at Maya Whole Health Studio. **Initial** _____

It is my responsibility to confirm that my insurance coverage will adequately cover any treatments I receive at Maya Whole Health Studio. I agree to pay for any reasonable and warranted charges for treatment received that is not ultimately covered by insurance provider. **Initial** _____

In the event that a 3rd party payer does not meet financial obligations for payment of fees for services that I receive at Maya Whole Health Studio, I will be accountable to make payment of any balance (or make arrangements to do so) within 30 days of notice. **Initial** _____

In the event that I disagree with any charges made by Maya Whole Health Studio for services that I receive, I will contact the Studio Coordinator to address the matter within 30 days of receiving notice of my obligation to pay charges. If charges are found to be reasonable and valid by Studio Coordinator, I will make arrangements for timely payment of account balances. **Initial** _____

In the event of a "no-show" I will be charged the full amount of the service scheduled. If I cancel within 24 hours of scheduled appointment, I may be charged 50% of the missed treatment. **Initial** _____

If I arrive late for an appointment, I understand that I may not receive services, or that I may receive partial services, due to need for practitioner to accommodate others on the schedule.

I certify that all information I have provided is true to the best of my knowledge and I understand and agree with the payment policy and cancellation procedures.

I understand that the services received at Maya Whole Health Studio are not considered to be conventional medical care and that these services do not serve as a substitute for emergency medical care.

I will inform my practitioner at Maya Whole Health Studio in a timely manner of any change in my physical health that could be attributed to any treatment provided.

I understand that the services provided at Maya Whole Health Studio are for the purpose of aiding in health maintenance and are non-sexual in nature.

I take full responsibility for how I proceed in regard to addressing any health concerns presented to practitioners at Maya Whole Health Studio. Any information provided by any practitioner at Maya Whole Health Studio is for educational purposes only.

By signing this form I waive any and all claims, damages, action and liabilities against Maya Whole Health Studio arising out of, or relating to any acupuncture, massage, or skincare services and allergic reactions to products and services suggested or sold.

Signature: _____ Date: _____

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Maya Whole Health Studio

Consent Form for Oriental Medicine Treatment

I, the undersigned, hereby authorize the acupuncturists at Maya Whole Health to perform the following specific procedures:

Acupuncture: insertion of thin, sterilized needles into the skin and underlying tissues at specific points on the body.

Cupping: a technique to relieve symptoms in which cups are placed on the skin with a vacuum created by heat or other devices.

Plum Blossom: a light tapping of an area of the body with a small sterile seven-star hammer or a single puncture with sterile lancet. These methods may be used to draw out a few drops of blood.

Gua Sha: a rubbing on an area of the body with a blunt, round instrument.

Herbs: may be given in the form of pills, powders, tinctures, pastes, plasters, or raw herbs. Herbs may be taken internally or used externally, and may include shell, mineral, and animal materials. *Note: Over 98% of the herbs used are botanical. Conditions may call for the use of an animal product. Do you wish to be informed if this is the case? [ ] Yes [ ] No*

Moxa: indirect or direct burning of mugwort (artemisia) on specific areas of the body.

Tui Na: a form of Chinese bodywork which may include massage or stretching.

Elecroacupuncture: stimulation of acupuncture points with a mild electrical current.

Heating Lamp and Heating Pad: warms areas of the body.

I recognize the potential risks and benefits of these procedures as described below:

Potential side effects: May include but are not limited to discomfort, pain, minor bruising, infection and blistering at the site of the procedure, broken or unremoved needles, temporary discoloration of the skin, loose bowel movements, abdominal cramping, and aggravation of symptoms existing prior to treatment. Occasionally needle sickness may occur (dizziness, nausea, or fainting). Risk of needle shock increases for patients with low blood sugar or severe lack of sleep. For this reason, it is recommended that patients always eat prior to receiving treatment.

Potential benefits: Relief of symptoms, resolution of underlying condition, prevention of recurrence, and increased overall health.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Maya Whole Health Acupuncturists regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of my health services provided to me. This record will be kept confidential and not be released to others without my consent, unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three years, but no more than eight years after the date of my last treatment.

I have read and understood Maya Whole Health Studio's HIPAA Privacy Policies. Initial _____

_____ _____

Signature of Patient, Representative or Guardian Date

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Maya Whole Health Studio

Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Maya Whole Health Studio at Southport respects your privacy and understands that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information created and obtained while providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatments, health information from other providers, and billing and payment information relating to these services. Federal and state law allows use and disclosure of your protected health information for purposes of treatment and health care operations. State law requires your authorization to disclose this information for payment purposes.

Examples of Use and Disclosure of Protected Health information for Treatment, Payment, and Health Operations

Information obtained by members of our health care team will be recorded in your medical record and used to help decided what care may be right for you. We may also provide information to others providing care to you. This will help them stay informed about your care.

Health plans need information from us about your medical care if we are requesting payment from them. Information provided to health plans may include your diagnosis, procedures performed, or recommended care.

We may contact you to remind you about appointments and give you information about treatment alternatives or other health related benefit services.

Your Health Information Rights

The health and billing records I create and store are property of Maya Whole Health Studio at Southport. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read, ask questions about this notice
- Ask in writing to restrict certain uses and disclosures. We are not required to agree to those restrictions, but will review your request and inform you to any action taken
- Request in writing that you be allowed to see a copy of your protected health information
- Have us review a denial of access to your health information – except in certain circumstances
- Ask in writing to change your health information. You may write a statement of disagreement if your request is denied. It will be stored in your medical record and included in any release of your records
- Cancel prior authorization to use or disclose health information by providing a written revocation

Our responsibilities Include

Following the terms of this notice. However, we have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this notice. You may receive the most recent copy of this notice by calling and asking for one.

We respect your right to file a complaint with us or with the U.S. Secretary of Health and Human Services. If you complain we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information

Notification of family and others:
Unless you object, health information about you may be released to a friend or family member who may be involved in your medical care.

You have the right to object to this use or disclosure of your information. If you object, we will not use or disclose it. We may ask you to provide a written statement listing persons with whom you wish your health information to be shared, and those to whom you do not wish your information to be given.

Possible Disclosure of your Protected Health Information Without your Authorization

For public health and safety purposes as allowed or required by law

To report suspected abuse or neglect to public authorities

For law enforcement purposes such as when we receive a subpoena, court ordered, or other legal process, or you are the victim of a crime

For health and safety oversight activities

For disaster relief purposes

Uses and disclosures not on this notice will be made only as allowed or required by law or with your written authorization.

If you have any questions about this notice, want more information, or want to report a problem about the handling of your protected health information you may contact:
Maya Whole Health Studio at Southport
1322 Lake Washington Blvd Ste. 3
Renton, Wa. 98056
425.271.0200

Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to oyhers unless you direct us to do so, or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Maya Whole Health Studio.

By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed Name Relationship (if signed on behalf of the patient)

Under no circumstances will your private health information be exchanged or sold to private vendors.