Hudson Valley Integrated Medicine
300 East Route 59, Suite 112
Nanuet, NY 10954

PATIENT INFORMATION

Last Name _____ First Name_____ Middle Initial_____

Marital Status: _____ Gender: M or F

Street Address_____

City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

Email Address _____ Date of Birth _____

Race _____ Ethnicity _____ Preferred language_____

Occupation: _____ Employer: _____

EMERGENCY CONTACT

Name _____ Relationship _____

Phone Number _____

INSURANCE INFORMATION

Cardholder's Name _____ Relationship to Patient _____

Cardholder's Date of Birth _____

Address _____ City _____ State _____ Zip Code_____

Primary Insurance _____ Policy/ID Number _____

Group # _____

Address _____ City _____ State _____ Zip Code _____

Secondary Insurance _____ Policy/ ID Number _____

Group # _____

Address _____ City _____ State _____ Zip Code _____

Is this a work-related injury or illness? (Please Circle) Yes No

REFERRING PHYSICIAN INFORMATION (if any)

Referring Physician: _____ Tel: _____ Fax: _____

Referring Physician Address: _____

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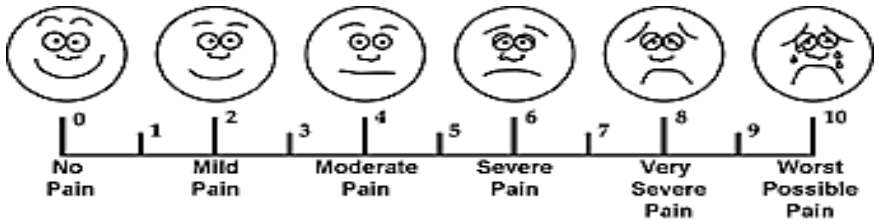
PATIENT NAME: _____ DATE: _____
Date of Birth: _____

Medical History (all information is strictly confidential)
Check symptoms you currently have or have had in the past year.

Please describe the health concerns that have brought you here today:
_____

If pain, please describe location, how long it's been going on, and the intensity from 1-10: _____



Past treatment for this condition: _____
_____

Prior Tests for this Problem	Of What:	Where (Facility):
☐X Ray	_____	_____
☐MRI	_____	_____
☐CT	_____	_____
☐Blood work	_____	_____
☐Other _____	_____	_____

Health Habits	Started	Stopped	How Often
☐Tobacco			
☐Alcohol			
☐Caffeine			
☐Recreational Drug			
☐Other			

Exercise: What type? _____ How Often? _____

Current Height: _____ Weight: _____
☐Allergies _____

☐Past Surgeries: _____

Medical History Cont.

☐Diabetes _____
☐Arthritis _____
☐High Blood Pressure _____
☐Heart Attack _____
☐Stroke _____
☐Asthma _____
☐Emphysema _____
☐Heart Burn _____
☐Thyroid _____
☐High Cholesterol _____
☐HIV _____
☐Hepatitis _____
☐Autoimmune _____
☐Depression _____
☐Anxiety _____
☐Seizures _____
☐Substance abuse history: _____
_____
☐Other _____

Women Only

Are you pregnant? ☐Yes ☐No
Number of children: _____
Date of last Period: _____
Pain associated with period: ☐Y☐N
Heavy Bleeding: ☐Yes ☐No
Date of last Pap smear: _____
Have you had a mammogram: ☐Yes☐No If yes, when? _____
☐Perimenopause
☐Menopause
☐Decreased Libido

Men Only

☐Prostate Problems
☐Decreased Libido
☐Impotence

Family History

	Mother	Father	Siblings	Children	Other
☐Heart Disease					
☐Hypertension					
☐Diabetes					
☐Cancer (type)					
☐Osteoporosis					
☐Autoimmune					
☐Asthma					
☐Allergies (type)					
☐Mental Health					
☐Substance Abuse					
☐Other					

Signatures

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____
Signature of Patient, Guardian, or Personal Representative Date

_____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient

Hudson Valley Integrated Medicine

Medication List

Name: _____ DOB: _____

Pharmacy: _____

Pharmacy Phone: _____

Please include all prescriptions, as well as all Over the Counter (OTC) medication's, and vitamins/supplements taken on a regular basis.

ALLERGIES TO ANY MEDICATIONS: _____

_____

Medication Name	Dose	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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ACUPUNCTURE CONSENT FORM

"Acupuncture" means the stimulation of a certain point or points near the surface of the body by the insertion of special needles. The purpose of acupuncture is to prevent or modify the perception of pain and is thus a form of pain control. In addition, through the normalization of physiological functions, it may also serve in the treatment of certain diseases or dysfunctions of the body.

Acupuncture includes the techniques of electro-acupuncture (the therapeutic use of weak electric currents at acupuncture points), mechanical stimulation (stimulation of an acupuncture point or points on or near the surface of the body by means of apparatus or instrument), and moxibustion (the therapeutic use of thermal stimulus at acupuncture points by burning Artemisia alone or Artemisia formulations).

The possible risks: slight pain or discomfort at the site of needle insertion. Rarely seen are infection, bruising, weakness, fainting, nausea, and aggravation of problematic systems existing prior to acupuncture treatment.

The potential benefits: acupuncture may allow for the painless relief of one's symptoms without the need for drugs, and improve balance of bodily energies leading to the prevention of illness, or the elimination of the presenting problem.

With this knowledge and understanding, I consent to the above procedures.

_____
Printed Name

_____ Date_____
Signature

_____ _____
Witness

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I have been presented with a copy of the Notice of Privacy Practices for the office of **HUDSON VALLEY INTEGRATED MEDICINE,** detailing how my information may be used and disclosed as permitted under federal and state law.

Signed: _____ **Date**: _____

Print name: _____

If not signed by patient, please indicate relationship to patient (e.g., parent, guardian) and patient's name.

Patient: _____

Relationship:_____

NOTICE OF CANCELLATION POLICY:

This office requires at least 24 hours notice for all cancellations. Patients who fail to do so or no show for their scheduled appointments will be charged **$50**.

_____ I acknowledge that I have read and
(**print name**)

understand the **NOTICE OF CANCELLATION POLICY**.

Signed: _____ Date: _____

Hudson Valley Integrated Medicine

ASSIGNMENT OF BENEFITS

I hereby authorize the direct payment of medical benefits to **Hudson Valley Integrated Medicine, PLLC** for services rendered. I understand that I am financially responsible for any charges not covered by my insurance carrier(s). This may include deductibles, co-payments, co-insurance, and denied (not covered) services.

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be valid as an original.

Signature _____ Date _____

Name: _____ DOB: _____

RELEASE OF INFORMATION

I authorize **Hudson Valley Integrated Medicine, PLLC** to release any necessary medical information to process my insurance claims.

Signature _____ Date _____

GUARANTEE OF PAYMENT

In consideration of the services rendered by **Hudson Valley Integrated Medicine PLLC**, I, The undersigned, agree to pay **Hudson Valley Integrated Medicine PLLC** any co-payment, co-insurance or deductible mandated by my health insurance plan. In addition, I agree to pay for all services that are not covered by my health insurance plan provided that I am informed of same prior to rendering of said services.

Signature _____ Date _____

Hudson Valley Integrated Medicine, PLLC

Hudson Valley Integrated Medicine, PLLC is an out of network provider with your insurance plan. Your insurance company will be sending any and all correspondence including, but not limited to, **payment for services rendered in our office, explanation of benefits and/or denials of service to your home.** It is the responsibility of the patient to forward this to the office.

If you have any questions, please do not hesitate to speak to our staff.

_____

I have read and understand the above terms.

Printed name_____

Signature_____

Date_____