Lotus Holistic Wellness, LLC

Name: _____ DOB: _____ Age:_____

Home Phone: _____ Cell: _____ Work: _____

Email: _____

Gender: ☐ Male ☐Female ☐ Gender Identify As:_____ ☐ Trans ☐ Other _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other _____

Primary Address:_____

City: _____ State: _____ Zip: _____

Alternate / Seasonal Address:_____

City: _____ State: _____ Zip: _____

Preferred method of communication: ☐ Text ☐ Phone Call (☐ Cell ☐ Home) ☐ Email

Would you like to receive appointment reminders via text? ☐ Yes ☐ No Via Email? ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ FT/PT Student ☐ Retired ☐ Other _____

Employer: _____ Occupation/Title: _____

Have you had acupuncture or herbal medicine before? ☐ No ☐ Yes If yes, for the treatment of what condition?
_____ Did it help resolve the condition? ☐ No ☐ Yes

Do you have a referral from another healthcare professional? ☐ No ☐ Yes If Yes, who is the referring healthcare professional?
_____Phone:_____

What is the reason you are being referred to our office?_____

Are you under the care of any other healthcare professionals? ☐ No ☐ Yes If Yes, who?
_____ Phone:_____

_____ Phone:_____

Are you claustrophobic? ☐ No ☐ Yes

Do you have a fear needles? ☐ No ☐ Yes If yes, do you ever faint when needles are used? ☐ No ☐ Yes

What are your goals for this treatment today? _____

Are there any areas that you would not be comfortable in having treatment on? (Example: feet, scalp, face, gluteal region, stomach, etc)

☐ No ☐ Yes If Yes, where? _____

Is there anything that you are aware of that would prevent you from reaching your longterm healthcare goals? ☐ No ☐ Yes

If Yes, please elaborate:_____

What is the major source of joy in your life? _____

What is your level of commitment to improving your health? (Circle your current commitment to your health and wellness below)

1 2 3 4 5 6 7 8 9 10 (10 = 100%)

Please answer the following pertaining to your visit today:

What is the reason for your visit today? _____

Please identify in detail the condition(s) that brought you to this office:

Primary Concern/Condition: _____

Secondary Concern/Condition: _____

When and how did the problem(s) begin? _____

_____

Was the onset (how quickly) did the condition begin? ☐ "All of a sudden" ☐ Gradually over time / time frame:_____

Is there anything that <u>improves</u> your condition(s)/symptoms(s)?_____

Anything that <u>worsens</u> your condition(s)/symptom(s)?_____

<u>Are you currently experiencing any pain?</u> ☐ No ☐ Yes

If Yes, what is the severity of your pain on a scale of 0 to 10? (0 being no pain, 10 being severe pain)

(Circle your current pain level) **0 1 2 3 4 5 6 7 8 9 10**

No Pain Moderate Severe

What is the frequency of discomfort?

☐ Continuous ☐ Intermittent ☐ Occasional ☐ Frequent ☐ Improving ☐ Worsening

<u>I would describe my pain or condition as:</u>

☐ **Mild** (I know it's there but does not stop activities, etc)

☐ **Moderate** (disrupts my activities/makes daily activities more challenging or uncomfortable)

☐ **Severe** (keeps me from daily activities/uncomfortable/intolerable)

<u>Tell me more about your pain, is it:</u> <u>(Circle all that apply)</u>

☐ Radiating/Traveling ☐ Dull ☐ Sharp ☐ Ache ☐ Shooting ☐ Throbbing ☐ Burning

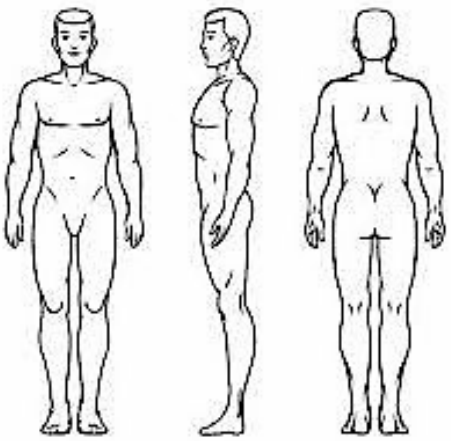
☐ Muscle Spasms ☐ Localized ☐ Itchy. ☐ Bruised ☐ Cold Sensation ☐ Hot Sensation ☐ Stabbing

☐ Swelling/Redness ☐ Numbness/Tingling ☐ Heavy Sensation ☐ Tight or Stiffness ☐ Muscle Aches

☐"Nerve like" Pain ☐ "Pins & Needles" ☐ "Moving" or "Changes Areas" ☐ Better with pressure

☐ Worse with pressure ☐ Other _____

<u>Circle all the areas of pain below:</u>



Was the condition treated by anyone in the past?

☐ No ☐ Yes If Yes, What type of treatment did you have?

_____

_____

Did it help? ☐ No ☐ Yes ☐ Don't know/unsure if it helped

What other types of home care do you use/have tried for your pain/condition?

_____

_____

Medical History

Do you have any *ALLERGIES* or have had a reaction or sensitivity to ANYTHING? ☐ No ☐ Yes If Yes, Please specify/list below:

_____

Allergies/Sensitivities: ☐ Environmental (pollens, dust, sun exposure, etc) ☐ Metals ☐ Perfumes ☐ Animals/Pet Dander ☐ Foods (☐ Lactose Intolerant / Dairy / Milk ☐ Wheat / Gluten ☐ Corn ☐ Fruits ☐ Peanuts ☐ Sugars ☐ Vegetables) ☐ Latex ☐ Adhesives / Glues ☐ Chemicals ☐ Other_____ Do you have a epipen? ☐ No ☐ Yes

Medications and Supplements

Are you currently taking any medications, vitamins, herbal supplements or other over the counter medications? ☐ No ☐ Yes
If Yes, Please list all current medications, vitamins, herbal supplements and other over the counter medications below:

_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____
_____ For:_____ Dose/ Frequency:_____

Operations: Please list below any surgeries/procedures/treatments and dates of each:
(ex: Hysterectomy, Rotator Cuff, Hip Replacement, Mammogram, etc)

_____Date:_____ _____Date:_____
_____Date:_____ _____Date:_____
_____Date:_____ _____Date:_____
_____Date:_____ _____Date:_____

Do you have any medical implants? ☐ No ☐ Yes If Yes, please list: _____

Diet/Lifestyle:

Do you work out/exercise on a regular basis? ☐ No ☐ Yes If Yes, How often do you exercise? _____

Please describe your current fitness routine: _____

Please indicate if and how often you consume the following:

☐ Coffee _____ ☐ Tea _____ ☐ Cigarettes/Vape/Tobacco _____

☐ Carbonated Beverages _____ ☐ Recreational Drugs _____ ☐ Alcohol _____

☐ Medical or recreational marijuana _____ ☐ Other_____

What type of diet do you follow? ☐ Regular Diet ☐ Vegetarian ☐ Vegan ☐ Restricted/Medical Diet ☐ Other

Review of Systems *Please check any of the following you have/had in the past:*

Temperature/Perspiration

- ☐ Night Sweats
- ☐ Daytime sweats/Hot Flashes
- ☐ Sweats easily on exertion or with any activity
- ☐ Cold: ☐ Hands ☐ Feet ☐ Limbs ☐ Other: _____
- ☐ Low grade fevers
- ☐ Warm: ☐ Hands ☐ Feet ☐ Limbs ☐ Other: _____
- ☐ Desire to be covered up
- ☐ Chills / Chilled/ Cold Easily
- ☐ Raynaud's Syndrome
- ☐ Profuse Sweating
- ☐ Sweaty: ☐ Hands ☐ Feet ☐ Other: _____
- ☐ Foul smelling sweat
- ☐ Lack of sweating

Sleep

- ☐ How many hours of sleep do you average per night? _____
- ☐ Waking often at night/early morning - how many times? _____
- ☐ Restless Sleep
- ☐ Currently using sleep medication/OTC sleep aids
- ☐ Snoring
- ☐ Waking up with dry mouth
- ☐ Wakes often at night/difficulty staying asleep
- ☐ Difficulty falling asleep
- ☐ Difficulty waking up/feeling groggy in the morning
- ☐ Feeling unrested after a full night's sleep
- ☐ Dream disturbed sleep / Nightmares / Excessive Dreaming
- ☐ Sleep apnea CPAP? ☐ No ☐ Yes
- ☐ Sleep walking/talking

Constitutional & Energy

- ☐ Fatigue
- ☐ "Extreme" Fatigue/Exhaustion
- ☐ Tires easily with activity
- ☐ Unintended weight loss/weight gain
- ☐ Low Energy
- ☐ Wanting to "sleep all the time"
- ☐ High energy/"Feeling Wired"
- ☐ Thinking all the time/"Can't Quiet the Mind"

Appetite & Thirst

- ☐ Lack of appetite or Low appetite
- ☐ Insatiable appetite or "Hungry all the time"
- ☐ Change in appetite or thirst
- ☐ Strong thirst/thirsty all the time
- ☐ Prefer cold drinks
- ☐ Prefer warm or hot beverages
- ☐ Food Cravings -anything specific?_____

Mental & Emotional Health

- ☐ Anxiety
- ☐ Panic Attacks
- ☐ Depression
- ☐ PTSD
- ☐ Excessive Worry
- ☐ Feeling Anxious/Overwhelmed
- ☐ Uncontrollable crying
- ☐ Recent Grief/loss/Sadness
- ☐ Trauma Survivor
- ☐ Disinterest in activities
- ☐ Avoiding social interactions
- ☐ Sensory Disorder
- ☐ Bipolar Disorder
- ☐ Seasonal Affective Disorder
- ☐ Schizophrenia
- ☐ Considered/Attempted Suicide
- ☐ Multiple/Borderline Personality Disorder
- ☐ Alcoholism or History of Addiction - In recovery? ☐ No ☐ Yes
- ☐ Other_____
- ☐ Under the care of a counselor/mental health therapist/psychologist

Cardiovascular

- ☐ High cholesterol
- ☐ Chest Pain/Angina -where? _____
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Arteriosclerosis
- ☐ Stents
- ☐ Blood Clots
- ☐ On blood thinners
- ☐ Heart Arrhythmias
- ☐ Swollen hands/feet
- ☐ Open heart surgery
- ☐ Stroke
- ☐ Phlebitis
- ☐ Edema
- ☐ Excessive bruising
- ☐ Fainting
- ☐ Congestive Heart Failure
- ☐ Pace Maker
- ☐ Palpitations/Irregular Heartbeat
- ☐ Heart Attack
- ☐ Mitral Valve Prolapse/Valve Replacement
- ☐ Lymphedema
- ☐ Peripheral Artery Disease (PAD)
- ☐ Other:_____

Immunological & Hemological

- ☐ Cancer - What type? _____Treatment type:_____
- ☐ IgG/IgA Deficiencies / Immune Deficiencies
- ☐ Compromised Immune System / Low Immune System
- ☐ Takes longer to recover from illness/sickness than average
- ☐ Autoimmune Disorders: What type? *(such as Lupus, Sjogren's, RA, Hashimoto's, etc)*_____
- ☐ Anemia - Type of anemia?_____ Are you being treated by a hematologist? ☐ Yes ☐ No
- ☐ Hemophilia / Bleeding Disorder
- ☐ Aids/HIV Positive
- ☐ Other _____

Neurological

- ☐ Memory loss
- ☐ Dementia
- ☐ Brain Fog
- ☐ Autism/Spectrum Disorder
- ☐ Nerve Pain - Where?_____
- ☐ Hypersensitive to sounds and noises
- ☐ Neuropathy
- ☐ ADHD/ADD
- ☐ Traumatic Brain Injury
- ☐ Alzheimer's Disease
- ☐ Tremors
- ☐ Nerve Damage
- ☐ Obsessive Compulsive Disorder
- ☐ Sensory Processing Disorder
- ☐ Difficulty Focusing
- ☐ Epilepsy/Seizures
- ☐ Parkinson's Disease
- ☐ Numbness
- ☐ Multiple Sclerosis
- ☐ Rheumatic Fever
- ☐ Bell's Palsy
- ☐ Shingles - where/when?_____
- ☐ Lyme disease
- ☐ Trigeminal Neuralgia
- ☐ Occipital Neuralgia
- ☐ Restless Leg Syndrome
- ☐ Other: _____

Digestive / Gastrointestinal System

- ☐ Heartburn/Acid Reflux
- ☐ Barrett's Esophagus
- ☐ Diarrhea
- ☐ Constipation
- ☐ Incontinence of bowels
- ☐ Crohn's Disease
- ☐ Vomiting ☐ Vomiting Blood
- ☐ Nausea
- ☐ Gas
- ☐ Eating Disorder - Anorexia/Bulimia
- ☐ Pancreatitis/Pancreatic Disease
- ☐ IBS
- ☐ Hepatitis: What type?_____
- ☐ Diverticulitis/Diverticulosis
- ☐ SIBO
- ☐ Dysbiosis
- ☐ H. Pylori
- ☐ Increased Motility in the GI tract
- ☐ Hemorrhoids - with Bleeding? ☐ No ☐ Yes
- ☐ Leaky Gut
- ☐ Celiac Disease
- ☐ Abdominal distention/bloating
- ☐ Gallstones/Gallbladder Disease
- ☐ Hernia - Where?_____
- ☐ Liver Disease/Cirrhosis
- ☐ Low HCL
- ☐ Colitis
- ☐ Belching
- ☐ Gastric Sleeve / Weight Loss Surgery
- ☐ Ulcerative Colitis
- ☐ Abdominal pain or cramps
- ☐ Peptic/Duodenum Ulcer
- ☐ Other: _____

Bowel Movements

How often do you have a bowel movement?

_____ x daily / or every _____ days

- ☐ Recent changes in bowel habits
  - ☐ Loose Stools
  - ☐ Blood in stools

  Color _____

  Texture_____

  Formed? ☐ No ☐ Yes

  Undigested foods in stool? ☐ No ☐ Yes
- ☐ Mucus in stool
- ☐ Laxatives/Stool Softeners/Enemas
- ☐ Other: _____

Sensory & Head

- ☐ Blurred vision
- ☐ Dry eyes
- ☐ Excessive tearing or "watery eyes"
- ☐ Itchy eyes
- ☐ Red eyes
- ☐ Eye pain
- ☐ Cateracts
- ☐ Glaucoma
- ☐ Night blindness
- ☐ Autoimmune Eye Disorders
- ☐ Double vision/Tunnel vision
- ☐ Ears ringing (Tinnitus)
- ☐ Hearing loss/Diminished hearing
- ☐ Ear pain/earaches/ear infection
- ☐ Hay Fever/Seasonal Allergies
- ☐ Headaches ☐ Tension ☐ Cluster ☐ Hormonal ☐ Other

  Location: ☐ Occiput/back of the head ☐ Behind the eyes

  ☐ Vertex/top of the head ☐ Whole head

  ☐ Forehead/frontal sinuses/around the eyes

  ☐ Temples/sides of the head
- ☐ Migraines (how often?) _____

  Auras or visual disturbances? ☐ No ☐ Yes

  Nausea/Vomiting? ☐ No ☐ Yes

  Does anything improve or make it worse? _____
- ☐ Dizziness/Lightheaded
- ☐ Facial pain
- ☐ Jaw pain/TMJ
- ☐ Vertigo
- ☐ Other: _____
- ☐ Nose bleeds
- ☐ Loss of smell/Loss of taste
- ☐ Nasal congestion
- ☐ Excessive Saliva
- ☐ Dry mouth/Dry throat
- ☐ Gum problems
- ☐ Bad breath
- ☐ Grinding of teeth
- ☐ Teeth problems
- ☐ Toothache
- ☐ Lip sores
- ☐ Mouth sores/ulcers
- ☐ Recurrent sore throat

Genitourinary / Urinary

- ☐ Pain on Urination
- ☐ Unable to hold urine/Incontinence of urine
- ☐ Frequent urination
- ☐ Difficulty urinating
- ☐ Urgency to urinate
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Frequent urinary tract infections
- ☐ Cloudy Urine
- ☐ Kidney Stones
- ☐ Kidney Disease: type?_____
- ☐ Kidney Failure: What stage?_____ On Dialysis? ☐ No ☐ Yes
- ☐ Catheter use
- ☐ Wake up at night to urinate
- ☐ Genital itching/rashes
- ☐ Sexually transmitted disease - Type:_____
- ☐ Other_____

Endocrine

- ☐ Hypothyroid (underactive thyroid)
- ☐ Hyperthyroid (overactive thyroid)
- ☐ Thyroid/Parathyroid Disease - Type: _____
- ☐ Hypoglycemia/Low Blood Sugar
- ☐ Diabetes - What type: ☐ Type 2 ☐ Type 1 ☐ Gestational Test blood sugar at home? ☐ No ☐ Yes
  What type of treatment are you on? (Check all that apply)
  ☐ Diet ☐ Insulin injection ☐ Insulin pump ☐ Glucose Monitor ☐ GLP-1 ☐ Oral medication (pill)
  ☐ Other_____
  Are there any diabetes related complications or other health issues that you have experienced? ☐ No ☐ Yes
  If Yes, please explain:_____

- ☐ Adrenal insufficiency
- ☐ Hashimoto's Disease
- ☐ Thyroid nodules
- ☐ Cortisol Issues
- ☐ Grave's Disease
- ☐ Addison's Disease
- ☐ Cushing's Disease
- ☐ Pituitary Disorder
- ☐ Other _____

Respiratory

- ☐ Asthma - Type: ☐ Allergic Asthma ☐ Exercise Induced
- ☐ Wheezing
- ☐ Shortness of breath/Difficulty breathing on exertion
- ☐ COPD / Emphysema / Chronic Bronchitis
- ☐ Cough - ☐ Dry Cough ☐ Cough w/phlegm ☐ Cough w/blood in sputum
- ☐ Tightness in Chest
- ☐ Pneumonia (frequent)
- ☐ Tuberculosis
- ☐ Cystic Fibrosis
- ☐ Alpha-1 Antitrypsin Deficiency
- ☐ On Supplemental Oxygen
- ☐ Other :_____

Covid-19:

Have you ever had Covid-19? ☐ No ☐ Yes
If Yes, when?_____

Do you have any lasting symptoms from your Covid-19 infection/Long Covid? ☐ No ☐ Yes If Yes, what are the ongoing symptoms you are experiencing?

_____
_____
_____

Do you have lung scarring from Covid infection? ☐ No ☐ Yes

Integumentary/Dermatological

- ☐ Psoriasis
- ☐ Eczema
- ☐ Acne or breakouts
- ☐ Sensitive skin
- ☐ Rashes - Where?_____
- ☐ Hives - Where?_____
- ☐ Itching - Where?_____
- ☐ Ulcerations in the skin
- ☐ Hair loss
- ☐ Varicose Veins
- ☐ Brittle nails
- ☐ Keloid Scarring
- ☐ Open skin/stitches

- ☐ Dry skin
- ☐ Rough/scaly skin
- ☐ Hyperpigmentation of the skin/dark patches
- ☐ Lumps
- ☐ Sunburn (current)
- ☐ Lichen Planus
- ☐ Skin Allergies
- ☐ Skin Cancer - where?_____
- ☐ Roseacea
- ☐ Change in appearance or texture of: ☐ Nails ☐ Skin ☐ Hair ☐ Mole/wart(s)
- ☐ Do you have any other concerns pertaining to your skin, nails or hair? ☐ No ☐ Yes If Yes, Please elaborate:_____
  _____

Men's Health

- ☐ Low Testosterone
- ☐ Testosterone Replacement Therapy (TRT)
- ☐ Low Libido
- ☐ Enlarged Prostate/BPH
- ☐ Impotency / Erectile Dysfunction
- ☐ Testicular Cancer/Cancer
- ☐ Swelling of Testicles
- ☐ Undescended Testicle

- ☐ Groin Pain
- ☐ Urinary Difficulty
- ☐ Gyneocomastia
- ☐ Male Infertility
  - ☐ Low Sperm Count
  - ☐ Low Motility
  - ☐ Low Sperm Quality
- ☐ Other _____

Is there anything not listed previously regarding your health that you are experiencing that would like to discuss? ☐ No ☐ Yes If Yes, Please elaborate: _____

Women's Health

Menstrual Cycles

Do you get regular PAP Smears and GYN checkups?

☐ No ☐ Yes

Age of first menses:_____Length of period (days)_____

Date of last menstrual cycle_____/_____/_____

Duration of flow:_____

Color: ☐ Purple ☐ Dark/Bright Red ☐ Pale

☐ Black, very dark ☐ Brown ☐ Scarlet red

☐ Irregular periods

☐ Heavy flow

☐ Very painful periods: *(check all that apply)*

☐ Mild cramping ☐ Moderate cramping

☐ Severe pain, stabbing ☐ Severe cramping

☐ Pain after period ☐ Cramping relieved by heat

☐ Pain before period ☐ Pain during period

How long does the pain/cramping last? _____

☐ Early periods

☐ Late periods

☐ Skipped periods - how often? _____

☐ Clots in flow - ☐ Dark ☐ Large ☐ Small

☐ Breast tenderness during menstrual cycle

☐ PMS / PMDD

☐ Endometriosis

☐ Pelvic Inflammatory Disease (PID)

☐ Ovarian Cysts

☐ Depression that is worse with menstrual cycle

☐ Pelvic floor disorder

☐ Prolapse Uterus or Bladder

☐ Night Sweats

☐ Hot Flashes/Feeling "warm all the time"

☐ Low Libido/Low Desire

☐ Menopause/Peri-menopause/Post-menopause - what age of onset? _____ Continued symptoms? ☐ No ☐ Yes

☐ HRT (hormone replacement therapy) How long?_____

☐ Uterine fibroids

☐ Hysterectomy - ☐ Full (w/removal of ovaries)

☐ Partial (still have ovaries)

☐ Poly Cystic Ovary Syndrome

☐ History of Cervical, Uterine or Ovarian Cancer

☐ Vaginal dryness

☐ Vaginal Atrophy Disorder

☐ Vaginal sores

☐ Candida Infection

☐ Yeast Infections / Vaginal Discharge:

☐ White ☐ Yellow ☐ Green ☐ Brown/Dark colored

☐ Red & White ☐ Watery Thick ☐ Itchy ☐ Burning

Foul odor: ☐ Fishy ☐ Leathery

Breast Health

When was your last mammogram? _____/_____/_____

Do you do monthly self breast exams? ☐ No ☐ Yes

☐ Breast cancer - Mastectomy? ☐ No ☐ Yes If Yes, when?

_____/_____/_____ Lymph node removal? ☐ No ☐ Yes

Additional treatments? ☐ No ☐ Yes If Yes, what type:_____

☐ Discharge from nipples

☐ Fibrocystic breast disease / breast densities

Pregnancy & Fertility

Are you currently pregnant or may be pregnant? ☐ **No** ☐ **Yes If Yes, what is your expected due date? _____/_____/_____**

Any **complications** during your pregnancy? ☐ No ☐ Yes If Yes, please explain:_____

_____

_____

OB/GYN provider:_____

Number of pregnancies: _____ Number of births: _____

☐ History of Miscarriages

☐ Abortion(s)

☐ Premature births

☐ C-Section(s)

☐ Difficult birth(s)

☐ Currently trying to get pregnant

☐ Infertility IVF treatments? ☐ No ☐ Yes

type:_____

How many rounds/Successful? _____

_____

Under the current care of fertility specialist? ☐ No ☐ Yes

Fertility Specialist/Provider:_____

☐ Birth Control - What method/type_____

How long?_____

☐ History of Postpartum depression after giving birth

☐ Other: _____

Lotus Holistic Wellness, LLC

Patient Communication and Consent

Please list the family members, significant others or other persons, if any, whom we may inform about your general medical condition and/or your TCM diagnosis (including treatment, payment and health care)

Name_____ Phone Number_____ Relation: _____

Name_____ Phone Number_____ Relation: _____

Emergency Contact

Please list the family members, significant others or other persons, if any, whom we may inform about your medical condition in the event of a medical emergency:

Name_____ Phone Number_____ Relation: _____

Name_____ Phone Number_____ Relation: _____

Can confidential messages (ie: appointment reminders) be left on your telephone answering machine or voicemail? ☐ No ☐ Yes

(Initial) _____ I give my consent to be contacted by via phone, text and or email.

- Please print the telephone number where you want to receive calls about your appointments, lab results, or other health care information IF OTHER THAN YOUR PRIMARY PHONE NUMBER: _____

- May we contact your physician to discuss your diagnosis and/or any other pertinent information, as needed? ☐ No ☐ Yes

  If YES, Please provide physician's name and number _____

- Would you like to receive information about acupuncture, upcoming events, educational content regarding health and wellness, newsletters and/or other information on Acupuncture and Chinese Medicine? ☐ No ☐ Yes (via: ☐ Email ☐ Text)

PATIENT NAME (please print) _____

PATIENT/GUARDIAN SIGNATURE _____DATE _____

Lotus Holistic Wellness, LLC

Patient Acknowledgement of Privacy Practices & Financial Policy

Our notice of privacy practices provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to review your Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you could send to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent, In writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability act of 1996 (HIPPA).

<u>The Patient understands that:</u>

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice notebook that is posted in our clinic lobby.
- The Practice reserves the right to change the Notice of Privacy Practices.
- Lotus Holistic Wellness, LLC reserves the right to leave confidential messages (I.e. appointment reminders) on your telephone answering machine or voicemail if permissions are given for messaging regarding your care. Please print the telephone number where you want to receive calls about your appointments other than your home phone number:_____
- Correspondences from Lotus Holistic Wellness, LLC will be in a sealed envelope marked “confidential”.
- The patient may revoke this consent in writing at anytime with the Privacy Officer (Physician) and all the future disclosures will then cease.
- The Practice may condition treatment upon execution of this consent.

<u>Statement of Financial Policy</u>

- We accept all major credit cards, personal checks and HSA Health Savings Cards.
- We do not accept insurance payment.
- There is a $30.00 fee for all returned checks.
- 24 hour notice prior to cancelling an appointment is required to avoid a $25 cancellation fee.

I have read and understand the Lotus Holistic Wellness, LLC financial policy.

Patient Signature:_____ Date:_____

Relationship to patient: (if other than patient):_____

Witness:_____Date:_____