DR. WREN WILLOW, DOM
MEDICAL HISTORY FORM

Today's date:						
PATIENT INFORMATION						
Patient's last name:		First:		Middle:	Marital status (circle one):	
					Single / Mar / Div / Sep / Wid	
Birth date:	Age:	Sex:				
/ /		❑ M ❑ F				
Street address:			SS#:		Home phone:	
					( )	
City:		State:	ZIP Code:			
Occupation:	Employer:				Work phone:	
					( )	
INSURANCE INFORMATION						
Insurance name:						
Subscriber's name:	Address (if different):				Home phone:	
					( )	
Subscriber's SS#:	Birth date:	Group no.:	Policy no.:		Co-payment:	
	/ /				$	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
IN CASE OF EMERGENCY						
Name of local friend or relative:		Relationship to patient:			Phone:	
					( )	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Wren Willow, DOM or insurance company to release any information required to process my claims.

Patient/Guardian Signature	*Date*	*Physician Signature*	*Date*

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❑ Aids/HIV	❑ Diabetes	❑ Hysterectomy	❑ Seizures
❑ Alcoholism	❑ Emphysema	❑ Measles	❑ Stroke
❑ Allergies	❑ Epilepsy	❑ MS	❑ Surgery
❑ Appendicitis	❑ Goiter	❑ Mumps	❑ Thyroid
❑ Arteriosclerosis	❑ Gout	❑ Pacemaker	❑ TB
❑ Asthma	❑ Heart Disease	❑ Pneumonia	❑ Ulcers
❑ Cancer	❑ Hepatitis	❑ Polio	❑ Other
❑ Chickenpox	❑ Herpes		

CARDIOVASCULAR

❑ High Blood Pressure	❑ Low Blood Pressure	❑ Chest Pain	❑ Palpitations
❑ Dizziness			

EYES, EARS, HEAD, NOSE

❑ Glasses/Contacts	❑ Poor Night Vision	❑ Blurry Vision	❑ Itchy Eyes
❑ Tinnitus	❑ Deaf/Hard of Hearing		
❑ Headaches	❑ Migraines		
❑ Sinus Problems	❑ TMJ	❑ Cough ❑ dry ❑ wet	❑ Allergies

GASTROINTESTINAL

❑ Acid Reflux	❑ Bloating	❑ Bloody Stools	❑ Black Stools
❑ Constipation	❑ Diarrhea	❑ Gas	❑ Hemorrhoids
❑ Mucus in Stools	❑ Nausea	❑ Undigested Food	❑ Vomiting
❑ Laxative Use	❑ Bad Breath		

GENITO-URINARY, GYNECOLOGY

❑ Nighttime Urination	❑ Painful Urination	❑ Bloody Urination	❑ Lower Back Pain
❑ PMS	❑ Painful Menses	❑ Blood Clots	❑ Breast Tenderness
❑ Cramps	❑ Pregnant now?		
Menopausal Symptoms:	❑ Night Sweats	❑ Memory Loss	❑ Irritability

MUSCULOSCELETAL

❑ Neck/shoulder Pain	❑ Upper Back Pain	❑ Lower Back Pain

❑ Joint Pain Where?

❑ Muscle Pain Where?

Patient/Guardian Signature *Date* *Physician Signature* *Date*

1600C Lena St, Suite 2, Santa Fe, NM 87505 ◆ 505.660.2305

DR. WREN WILLOW, DOM
MEDICAL HISTORY FORM

Patient/Guardian Signature *Date* *Physician Signature* *Date*

INFORMED CONSENT

I hereby request and consent to the performance of Acupuncture/Oriental Medicine and/or massage therapy procedures on me (or on the patient named below, for whom I am legally responsible) by Dr. Karin Richvalsky A.K.A. Dr. Wren Willow and her associates ( ).

I realize there are some inherent risks from treatment by these procedures including but not limited to bruising, bleeding, minor abrasions and/or bums, or a possible temporary worsening of my symptoms.
I expect that the doctors will give me a verbal estimate of the number of times I may need, the frequency of the treatment, and the possible outcome of the diagnostic treatment or procedure. I do not expect the doctors or their representatives to be able to anticipate and explain all risks and complications, and I wish to rely on them to exercise their judgment to the best of their abilities during the course of my treatment.
I have had an opportunity to discuss with my doctor or therapist the nature and purpose of Acupuncture/Oriental Medicine and its procedures and potential outcomes. I understand the results are not guaranteed. I also understand that I shall have the choice to accept or reject the proposed diagnostic treatment or procedure, or any part of it.

I have read or have had read to me, the above named procedures. I intend this consent form to cover the entire course of treatment for my present the above consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to condition, and for any future condition(s) for which I seek treatment by this office, its doctors and therapists.

Patient/Guardian Signature *Date* *Physician Signature* *Date*

PATIENT'S STATEMENT OF PRIVACY RIGHTS

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that health care providers and others must achieve to protect the privacy of Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE, YOU:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.)
4. You have the right to specify how access to your health information is restricted and from whom.
5. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
6. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be part of a "chain of trust' under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
7. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
8. You are entitled to this practices best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
9. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.
10. You *have* the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
11. You have the right contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint at, Toll Free: 1-877-696- 6775 or E-Mail: www.hhs/gov/ocr

Patient/Guardian Signature *Date* *Physician Signature* *Date*

FINANCIAL POLICY

Accepted forms of payment are cash, check, Visa, MasterCard, and insurance.

There is an approximate 25% discount from billed rates for prompt payment at the time of service.

I can submit insurance claims for you if I am contracted with your plan; however insurance is a contract between you and your insurance company. You are ultimately financially responsible for any balance due.

I am currently contracted with the following companies:

- Blue Cross Blue Shield of NM
- Presbyterian
- United Health Care
- Cigna
- VA

Any balance remaining after your insurance has processed claims will be billed to you. Most plans have a ink on acupuncture services. You are responsible for the cost of treatment after this Inuit has been met.
If you have a deductible plan we ask for a $60 estimated payment at the time of service until your deductible has been met for the year.

A $50 fee is charged for missed appointments and cancellations with less than 24 hour notice.

Discounted rates for payment at the time of service range from $90 to $110 depending upon services performed and time spent.

Patient/Guardian Signature *Date* *Physician Signature* *Date*