YELLOWSTONE NATUROPATHIC CLINIC
720 N 30th St Billings, MT 59101 406-259-5096 Fax: 406-545-0044

Patient's **LEGAL** Name _____ aka/Nickname _____ Date _____

Date of Birth _____ Soc. Sec. #_____ Male ___ Female ___ Marital Status _____

Cell Phone:_____ Home Phone:_____

→Can we leave messages with detailed medical information at the contact phone numbers listed above?

(mark one) Yes _____ *No _____ **If "No", to remain HIPAA Compliant, we will be required to leave a vague message asking you to return our call to receive any medical information.*

Email Address:_____ *(used for appointment reminders and Patient Passport System)*

Residence Address (physical address) _____

City _____ State _____ Zip Code _____

Mailing Address (if different) _____

City _____ State _____ Zip Code _____

How long at present address? _____

If patient is a minor, parent/guardian's name _____

Employer _____ Work Phone Number _____

City _____ State _____ Zip Code _____

Responsible Party for Account _____

Address (if different from above) _____

City _____ State _____ Zip Code _____

In Case of Emergency, Whom Should We Notify? _____

Address _____ Relationship _____

Primary Contact Number _____ Alternate Phone Number _____

How did you learn of our Clinic?

Doctor Referral (which physician?) _____

(*circle one*) Personal Referral /Gazette / Simply Family / T.V. / Rimrock Neighbors / Social Media (*circle one*)

Other (please describe) _____

Payment is due at the time of service as we do **NOT** bill insurance.
We accept cash, check and all major credit cards.

Yellowstone Naturopathic Clinic will verify this contact information whenever you come in for an appointment. However, if your circumstances change, it is your responsibility to give us your new contact information.

Signature _____ Date _____

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Acupuncture Initial Visit

Patient Name: _____ DOB: _____

Please Answer the Following Questions:

Have you tried acupuncture before? ☐ Yes ☐ No
Are you nervous about needles? ☐ Yes ☐ No
Do you have a tendency to faint? ☐ Yes ☐ No
Do you bleed for a long time or bruise easily? ☐ Yes ☐ No
Have you eaten in the last 3 hours? ☐ Yes ☐ No
Do you have a communicable disease? ☐ Yes ☐ No

Have you ever had Hepatitis? ☐ Yes ☐ No
Do you have a pacemaker? ☐ Yes ☐ No
Women: Are you pregnant? ☐ Yes ☐ No
Do you have joint replacement? ☐ Yes ☐ No
Do you have diabetes? ☐ Yes ☐ No
Do you have any type of heart disease? ☐ Yes ☐ No

Present Health

Major Complaint: _____

Have you ever been given a diagnosis for your condition? ☐ Yes ☐ No If yes, then what was the diagnosis, when and by whom? _____

Current medical doctor: _____

Other healthcare professionals: _____

Other current health problems: _____

Symptoms - Check each symptom you currently have.

Wood
___ Irritability
___ Depression
___ Indecisive
___ Headaches/Migraines
___ Visual problems
___ Red Eyes
___ Dry/Itching eyes
___ Feeling of lump in throat
___ Clenching of teeth at night
___ Muscle cramping
___ Muscle twitching
___ Joints feel tight/stiff
___ Often up past 1AM
___ Cold hands/feet
___ Soft/Brittle nails
___ Craving/Avoiding sour foods

Water
___ Urinary problems
___ Weakness/Pain in lower back
___ Aching bones
___ Feel cold easily
___ Low sexual energy
___ Excess sexual desire
___ Fearful/Frightened easily
___ Poor memory
___ Loss of hair
___ Hearing problems
___ Ringing in ears
___ Craving/Avoiding salty food

Fire
___ Heart palpitations
___ Chest pain
___ Dizziness
___ Insomnia or vivid dreams
___ Easily startled
___ Restlessness/Agitation
___ Anxiety
___ Shortness of breath
___ Dreams are bothersome
___ Lack of joy in life
___ Craving/Avoiding bitter foods

Metal
___ Dry cough
___ Cough with sputum
___ Nasal discharge
___ Poor sense of smell
___ Nose bleeds
___ Itchy, red or painful throat
___ Dry mouth
___ Skin rashes
___ Itchy skin
___ Grief, sadness
___ Shortness of breath
___ Seasonal Allergies
___ Low resistance to colds or flu
___ Low physical stamina
___ Mild fever comes and goes
___ Hot palms of hands/soles of feet
___ Craving/Avoiding spicy foods

Earth
___ Heaviness anywhere in body
___ Fatigue
___ Hard to get up in the morning
___ Edema (swelling)
___ Muscles feel tired often
___ Easy bruising and bleeding
___ Bad breath
___ Low appetite
___ Snacking
___ Tendency towards hypoglycemia
___ Nausea
___ Vomiting
___ Gas/belching
___ Bloating
___ Hemorrhoids
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Indigestion/Heartburn
___ Over-thinking
___ Tendency to become obsessive
___ Craving/Avoiding sweets

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Acupuncture Consent Form

Print Patient Name: _____ **DOB:** _____

This consent form describes techniques typically used in Acupuncture and Oriental Medicine:

Acupuncture is the insertion of sterile, single use needles through the skin at specific designated points on the body surface. Often, we add a low wattage electrode to intensify the treatment to alleviate pain and/or symptoms.

Moxibustion is the indirect or direct burning of a traditional Chinese herb to help relieve current symptoms. This technique will warm an area or specific point on the body. Moxa enters the energy pathways to nourish tendons, remove blockages and bring circulation into an area.

Cupping is the use of glass or plastic cups to form a vacuum on a surface of the body. The treatment brings blood flow to the surface and can leave a bruising effect on the skin. Be advised you may incur discoloration in your skin where the cups are used.

The purpose of treatment is to obtain relief of your present symptoms and correct underlying causes of imbalances or discomforts through natural, traditional methods rather than through drugs or surgery.

Potential risks of this form of treatment may include but are not limited to: discomfort or infection around the insertion site, temporary bruising, or an aggravation of symptoms existing prior to the acupuncture treatment. If any problems arise during the course of treatment, it is important to contact the clinic, so your practitioner is aware of changes in your conditions and possible reactions. Molly Bina can be reached at the YNC's phone number 406-259-5096.

With this knowledge, I consent to the above procedures realizing that no guarantee has been given regarding cure or improvement of my condition. I understand and agree to pay the amount due to Molly Bina, LAc, ND at the time of service. I am aware that a specific amount of time is allotted for my treatment and arriving late will mean that my treatment time will be adjusted accordingly. ***I will give a 24-hour notice of intent to cancel or reschedule my appointment, except in an emergency. Missed appointments will be billed at current rates. Payment is due at time of service.***

_____ _____

Patient Signature Date

_____ _____

Molly Bina, LAc, ND Date

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The term 'health care provider(s)' in this form means Yellowstone Naturopathic Clinic, Oasis Health Spa, their physicians, employees and members of the medical staff who provide care to patients.

CONSENT TO TREAT

I give permission to all health care providers involved in my care to administer such examination, treatment, testing and procedures as they deem necessary in the course of my care.

RELEASE OF INFORMATION

I understand that as part of my health care, health care providers create and maintain health records that may include my health history, symptoms, examination and test results, diagnoses, treatment and any plan for care including future treatment. I understand that this information serves as a basis for planning my treatment and care and is a tool for routine health care operations including assessing quality and reviewing competency of our staff and/or other health care providers.

FINANCIAL RESPONSIBILITY

I agree to pay all charges for my health care treatment. If charges to my account are not paid after reasonable notice, the account shall be deemed delinquent. In the event that I default on payment of my account, I agree to be responsible for collection fees and interest due on amounts in default. If the debt is assigned to a third party for collection, I agree to be responsible for collection fees and interest due on amounts in default.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for use and disclosure of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. When it is appropriate and necessary we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

Print Patient Name:_____ **DOB:**_____

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request or refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliant Officer. You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

Patient's Representative(s): (the following must be filled out, even if the answer is none)
This person is a family member or friend who may call our office on your behalf. Unless their name is listed below, we will not be able to speak with them about your medical concerns.

*** I hereby authorize the following individuals to have access to my healthcare information:**

_____, Relationship to Patient _____
_____, Relationship to Patient _____
_____, Relationship to Patient _____

PHOTOGRAPH

I authorize YNC to take a photograph of me for my file. ☐ **Yes** ☐ **No**

A photo helps us improve medical care. Photos prevent identification errors and (in conjunction with written records) prompt our physicians in recalling your needs, concerns and medical issues. This image will not be shared outside of Yellowstone Naturopathic Clinic. The confidentiality of this image will be maintained in accordance with HIPPA regulations.

TERM

This consent will be in effect for one year from the date signed.

Printed Name of Patient _____ **Date** _____

Signature of Patient or Responsible Party _____

Responsible Party's Relationship to Patient _____

Witness _____ **Date** _____

** *If you would like a copy of this form, once signed, please ask the receptionist* **

Patient Compliance Assurance Notification

To our valued families and patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule". We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to insure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you, for being one of our highly valued patients!