WELCOME

1 PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

_____
Name of Doctor or Clinic

for any services furnished to me by that provider.

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

_____
Signature of Beneficiary, Guardian or Personal Representative

_____
Please print name of Beneficiary, Guardian or Personal Representative

_____ _____
Date Relationship to Beneficiary

3 PHONE NUMBERS

Home (_____) _____ Cell (_____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____

Work Phone (_____) _____

4 FAMILY HISTORY

Date of last physical examination _____

What is your reason for visit? _____

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
ALIVE	☐		☐		☐	
DECEASED	☐		☐		☐	

BROTHERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
SISTERS	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH
CHILDREN	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES**

☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis
☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other _____

5 HEALTH HISTORY

All information is strictly confidential.

Check (✓) symptoms you currently have or have had in the past year.

GENERAL

- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High/Low blood pressure
- ☐ Irregular/Rapid heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache/Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes/Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in moles
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period _____

Date of last Pap Smear _____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children _____

Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Describe serious illnesses or operations _____

6 MEDICATIONS/ALLERGIES

List medications you are currently taking _____

_____

Pharmacy Name _____

Phone (_____) _____

List allergies to medications or substances _____

_____

7 HEALTH HABITS

Check (✓) which you use and how much:

- ☐ Caffeine _____
- ☐ Street Drugs _____
- ☐ Tobacco _____
- ☐ Other _____

Check (✓) if your work exposes you to:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other _____

_____

8 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, Parent, Guardian or Personal Representative — Date

_____ _____

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

_____ _____

Reviewed By — Date

Avalon Healing Center, LLC
Dr. Lynnette M. Guida
15 Aspen Drive
Cheshire, Ct 06410

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE READ AND REVIEW CAREFULLY.

Federal law requires us to maintain the privacy of your health information. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. HIPAA gives you, the patient, new rights to understand and control how your health information is used. That law also requires us to give you this explanation of how we maintain the privacy of your health information. We reserve the right to change our policy practices, provided the changes conform to applicable laws. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, health care operations, health care reminders and for public benefit. Any other disclosure will require your written authorization.

- Treatment means providing or managing health care and related services by one or more health providers.
- Payment means such activities as obtaining reimbursement of services, billing or collection activities and utilization review.
- Health care operations include the business aspects of running the clinic, quality assessment, evaluating practitioner, provider performance, training programs, accreditation, certification or credentialling activities.
- Reminders means providing you with appointment reminders or to inform you of changes in the clinic services or hours by such means as postcards, voicemail messages or letters.
- Public benefit means the disclosure of information for the following types of reasons: for public health activities including disease and vital statistic reporting; to report abuse, neglect or domestic violence; to health oversight agencies; to law enforcement officers pursuant to subpoenas and other lawful processing; medical examiners and coroners; to avert a serious threat to health or safety; in connection with certain research activities; and as authorized by state and federal laws.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

With Your Authorization: Any other uses and disclosures will be made only with your written authorization. You must give such authorization in writing to disclose it for any purpose, including but not limited to having a copy sent to another physicians or receiving a copy for your own personal use. You may revoke such authorization in writing and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Chief Medical Officer.

Please See Reverse Side for Signatures

Avalon Healing Center, LLC
Dr. Lynnette M. Guida
15 Aspen Drive
Cheshire, Ct 06410

- The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include, labor, copying cost and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee.
- The right to amend your protected health information. Your request must be in writing and must include an explanation why we should amend your records. We may deny your request under certain circumstances.
- The right to receive an accounting of disclosures of your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel your privacy protections have been violated. If you want more information about our privacy practices or have questions or concerns, please contact us by phone 860-347-8800, fax 860-347-8801 or by the mail 670 Newfield Street Unit C, Middletown, Ct 06457. You may also submit a written complaint to the US Department of Health and Human Services, Office of Civil Rights about violations of provisions of this notice or the policies and procedures of our clinic. We will not retaliate against you for filing a complaint.

I have read and understand the above-stated information.

_____ _____

Patient's Name | Legal Guardian's Name (if under 16 y.o.)

_____ _____

Patient (or Guardian) Signature | Relationship to Patient

_____

Date

For more information about HIPPA or to file a complaint:

The US Department of Health and Human Services
Office of Civil Rights
200Independence Ave. SW
Washington, DC 20201
Phone: 202-619-0257
Toll Free: 877-696-6775

Please See Reverse Side for Signatures

Avalon Healing Center, LLC
Dr. Lynnette M. Guida
15 Aspen Drive
Cheshire, Ct 06410
(860) 347 - 8800

Patient Consent Form

I _____, have been informed of my treatment options by Dr. Lynnette M. Guida. Dr. Guida will explain each procedure and all possible outcomes of the procedure as well as any alternative choices for the treatment. At this time I may accept or reject the treatment. I understand that during treatment, and while under the care of Dr. Guida, it is necessary to reveal all pertinent information regarding my health including current medications, botanicals, or supplements. It is also necessary to report any adverse reactions to any treatments under her instruction. Failure to reveal all information may result in personal harm to which Dr. Lynnette Guida has no liability. The following are adverse reactions that occasionally occur during acupuncture treatments, Naturopathic care, or other Traditional Oriental treatments:

A) Acupuncture- may cause infrequent bleeding or bruising

B) Moxibustion- the burning of mugwort on or near the skin or acupuncture needles, may occasionally cause burning and blistering of the skin (first or second degree burn)

C) Cupping and Gua Sha- often causes bruising

D) Electrical Stimulation- interferes with pacemakers, and other implanted devices. The patient needs to inform the practitioner if they have any of these.

E) Bleeding- may cause local bruising or swelling of the area.

F) Botanicals and Nutritional Supplements – May cause minor stomach complaints such as nausea if taken on an empty stomach. Individual herbs and supplements may have different side effects if taken improperly or in too large a quantity. The directions on how to take the herb and/or supplement, and the possible adverse effects will be reviewed during the office visit.

G) Homeopathy and Bach Flower Essences - May cause a slight aggravation of symptoms for a short period of time.

I, _____, agree to all of the above information.

Signature of Patient or Guardian: _____ Date ____/____/____

Signature of Physician: _____

Date ____/____/____