Lawrence Howard, LAc, MSAc & Maria C. Massone RGMT
250 West Main Street, Bay Shore, New York, 11706 **(631)433-2184**
www.IronDogEnergetics.com **www.Onetwinflamesanctuary.com**

Office Policy 2016

Please initial then sign after reading

1. If you are late for an appointment you will be seen for the remainder of your appointment time in order to avoid delays for other patients. Initial here_____

2. Reminder calls/texts messages are typically given a day prior to treatment as a courtesy. However, the patient is held responsible to attend their appointments regardless of such reminders. Initial here_____

3. We reserve the right to immediately discharge a patient from our practice if a patient is abusive to the staff or refuses to follow our office policy or treatment plan. Initial here_____

4. If you are dissatisfied for any reason, please alert our office and we will make every effort to correct the problem and accommodate your needs. Initial here_____

Thank you for choosing Lawrence Howard, LAc, MSAc & Maria C. Massone RGMT to provide your acupuncture and energy healing needs. Your business is greatly appreciated.

Our office policy is designed to provide structure for our office so that we provide good consumer service and ensure that all patients receive the same quality service and treatment. We strive to make your experience a good one and welcome your helpful feedback.

By signing below you acknowledge that you have read this document and agree to abide by our office policies and fee schedule.

Patient's Name (Print)_____

Patient's Signature _____ Date_____

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Financial Policy 2016

Lawrence Howard, LAc, MSAc and Maria C. Massone RGMT recognize the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

1. **Payment**
    a. **Self-pay/Cash-** We require full payment at the time of services rendered.
    b. **Insurance:** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. All charges for treatment become due and payable sixty (60) days after the date of service.
    c. **Managed Care (HMO, PPO, etc):** co-payment amounts are due at the time of service. You will be charged $10.00 rebilling fee if you do not pay your Copay when services are rendered.

    All charges for treatment become due and payable sixty (60) days after the date of service. If not paid within 60 days, we will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

2. **Fees**
    a. **Returned checks:** $25.00
    b. **Same-Day Cancellation/Reschedule/"No-Show":**
        i. **Cash or Insurance paying patients:** $20.00. This fee is not billed to insurance companies and does not apply towards any deductable.
        ii. **Multiple treatment package paying patients**: forfeiture of the day's treatment plus $20.00.
    c. **Medical records**: 75 cents per page fee plus relevant postage fees for requested copies of medical records. Requests should be made in writing. Please note that HIPAA allows for 30 days time to fulfill the request or to inform of delay and expectation of the completion of the request within 30 days of the request.
3. **Expired multiple treatment packages:** the amount paid of the unused portion paid is used as a credit towards a cash treatment. For example, a three-treatment package purchased at $30.00 where two treatments remain unused after expiration will have $20.00 credited towards their next cash treatment.

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Patient's Name (Print)_____

Patient's Signature _____ Date_____

Acupuncture Medical History Form

Patient Name Last: First: Middle Initial:			Date
Address			Date of Birth
City	State	Zip	Tel:
Email			Cell:
Insurance	ID #	Policy Holder Name	
Insurance Claims Address		Date of Birth	
Phone#		Phone#	

Emergency Contact Name: 1.	Tel:	Relationship
2		

Are you:
□ single □ married □ divorced □ separated □ widowed □ partnership □ living with
□ same sex relationship

Have you been diagnosed with:
□Hepatitis, if so which one?____ □ HIV □ AIDS □ Tuberculosis
□Cancer if so, which one?_____ □ Heart problems □ Lung problems

Who referred you to this office?_____

COMPLAINTS/AILMENTS
What are your most important health concerns? Please list in order of importance:

1. _____ date of onset:_____
2. _____ date of onset:_____
3. _____ date of onset:_____
4. _____ date of onset:_____
5. _____ date of onset:_____

Are you under a physician's care for any of your health concerns? (please describe if appropriate):_____

_____

_____

Have you sought any other treatment(s) for any of your health concerns? (please describe):_____

_____

Is there anything that improves your condition?:_____

Is there anything that aggravates your condition?:_____

Have you had any blood tests, x-rays, CT scans, MRIs, EKGs, or other tests related to your health concerns within the past year? Please list & describe the results to the best of your knowledge and/or memory:

_____

Medications/Supplements/Allergies

Please indicate if you are taking any of the following:
□ blood thinners (warfarin, coumadin, etc.) □ cortisone or other steroids □ sleeping aids
□ diet pills (diuretics, appetite suppressants, etc.) □ thyroid medication □ laxatives
□ pain relievers (Tylenol, aspirin, etc.) □ tranquilizers/sedatives □ antacids (tums, etc.)

Hospitalization/Surgery

Date	Reason

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, minerals & supplements you are currently taking (include energy drinks, etc.):

Name	Dosage	Reason for taking	Date began taking

Please list any food or drug allergies:

Name	What happens

Lifestyle and Commitment to improvement

How much change are you willing to/able to make at this time to improve your health (please check)

	Complete "I'll do whatever it takes."	**Moderate** "If it's easy I'll try."	**Neutral** "Fix me."	**Unwilling** "Sounds good but that's not for me."	**Very Unwilling** "I have more important things to worry about."
Commitment to treatment					
Regularity of treatment					
Work					
Diet					
Exercise-general					
Exercise-recommended					
Sleep					
Postural habits					
Mental Outlook					

Treatment goal

□freedom from discomfort □prevention of worsening of main complaint □personal development

DAILY LIVING

How would you rate the following areas of your health in the past month.

Energy
□ Robust □Average □Fatigue □Exhausted

Stress/calm
□Very good □Calm □Comfortable □Mildly stressed □ Very stressed

Sleep
hours you sleep per night:_____ Time you go to bed:_____ Wake up?:_____
Do you sleep well?:_____Do you wake feeling rested?:_____
Digestion □ Great □ Good □ Fair □ Poor
Comments_____

Appetite
□ Great □ Good □ Fair □ Poor Comments_____
Diet □ Great □ Good □ Fair □ Poor Comments_____
Are you vegetarian or vegan? □ No □ Yes For how long?_____

Food / Drink:
Foods You Crave_____When?_____
Daily Water Intake_____Daily Soda Intake_____Caffeine? □ Yes □ No
Daily Coffee Intake_____Caffeine?□ Yes □ No__Daily Tea Intake_____Caffeine?□Yes □No
Do you drink alcohol? How Much?_____How Often?_____ Past Use? □ Yes □ No Date Stopped_____
Do you use tobacco? □ Yes □ No Past Use? □ Yes □ No Date Stopped_____
Do you use recreational drugs? □ Yes □ No If yes, then which?_____
Past Use? □ Yes □ No Date Stopped_____

Room Temperature
□Tend to feel hot □Tend to feel warm □ Tend to feel neutral □ Tend to feel cold

Stools
□ Great □ Good □ Fair □ Poor Comments_____ How many times per day?_____Do they feel complete? □ Yes □ No Stool consistency? □ Loose □ Formed □ Hard to Pass □ Other_____ Is there blood in your stools? □ No □ Yes How Often?_____

Urination
□ Great □ Good □ Fair □ Poor Comments_____ How many times per day?_____ What color is your urine?_____ After you've gone to sleep Do you get up to urinate? □ Yes□ No How Often?_____ Is your urination painful? □Yes□ No

Personal Health History

Please put a check mark (☑)by the symptoms that you have now (past few days). Place a star ☒) next to the ones you have noticed within the last three months.

Qi, Blood, Yin, Yang

□ anxiety
□ catches colds easily or frequently
□ chest pain traveling to shoulder
□ cold feet
□ cold hands
□ difficult to concentrate
□ dizziness
□ dream disturbed sleep
□ dry skin
□ fatigue
□ feverish in the afternoon or flushes
□ general weakness
□ heat sensations in hands, feet, chest
□ insomnia
□mental confusion
□ night sweats
□ palpitations
□ restlessness
□ sores on tip of tongue
□ speech problems
□ sweats easily
□ thirst, at night
□ you feel worse after exercise
□ you see floating black spots

LU

□ allergies
□ chills alternating with fever
□ cough
□ difficulty breathing
□ dry mouth, throat, nose
□ feeling achy
□ headaches
□ nasal discharge
□ nose bleeds
□ shortness of breath
□ sinus congestion
□ sneezing
□ sore throat
□ stiff neck/ shoulders

SP

□ abdominal bloating and / or gas after eating
□ belching
□ chest congestion
□ constipation
□ diarrhea
□ eating disorders
□ fatigue after eating
□ gas
□ general feeling of heaviness in your body
□ hemorrhoids
□ loose stools
□ low appetite
□ mental heaviness, sluggishness or fogginess
□ nausea
□ prolapsed organs (previously diagnosed)
□ swollen feet
□ swollen hands
□ you bruise easily

ST

□ bad breath
□ belching
□ bleeding, swollen or painful gums
□ burning sensation after eating
□ constipation
□ heartburn
□ large appetite
□ mouth sores (canker or cold sores)
□ stomach pain
□ vomiting

HT / PC

□ chest pain
□ edema
□ high blood pressure
□ insomnia
□ low blood pressure
□ palpitations
□ stroke
□ varicose veins

LR / GB

□ bitter taste in mouth
□ blood shot eyes
□ blurred vision
□ chest pain
□ convulsions
□ diarrhea alternating with constipation
□ difficulty swallowing
□ dry eyes
□ feeling of a lump in your throat
□ headache at the top of your head
□ hot flashes
□ muscle spasms, twitching, cramping
□ numbness of hands and feet
□ pain in rib cage
□ red, sore or irritated eyes
□ seizures
□ skin rashes
□ tight feeling in chest
□ TMJ or locked jaw
□ you anger easily
□ you feel better after exercise

KI / BL

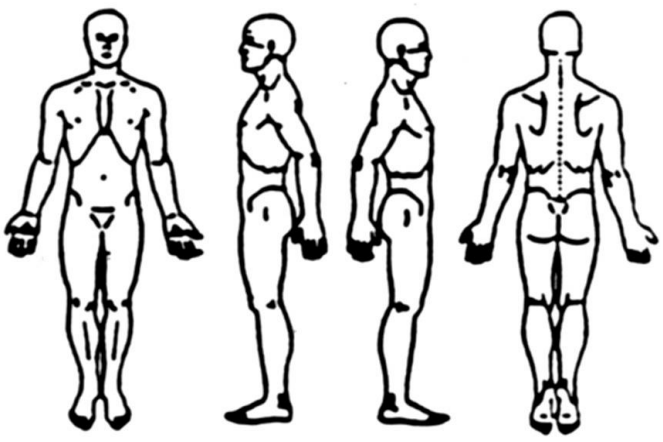
□ frequent urination
□ hair loss
□ joint pain
□ lack of bladder control
□ loose teeth
□ low back pain
□ memory problems
□ night blindness or low vision
□ ringing in your ears
□ sore, cold or weak knees
□ you get up more than one time at night to urinate

Other

_____
_____
_____
_____

Pain- Part 1

Please answer the following questions if you have pain.



Distress Associated with Pain
10 Agonizing
9
8 Horrible
7
6 Dreadful
5
4 Uncomfortable
3
2 Annoying
1
0 None. No distress

Indicate on the diagram your areas of pain

How long have you had this pain?_____

Describe the onset of your pain?

_____

_____

_____

_____

Do you take medications for this pain? (i.e.; medications, over the counter drugs, liniments) □ No □Yes_____

_____

Other treatments you have had for this pain?_____

_____

Anything you wish to add regarding your pain?

_____

_____

Pain- Part 2

Please use the Pain Scale below when answering questions regarding pain intensity.

Mankoski Pain Scale (0-10)

0 - Pain Free
1 - Very minor annoyance - occasional minor twinges. No medication needed.
2 - Minor Annoyance - occasional strong twinges. No medication needed.
3 - Annoying enough to be distracting. Mild painkillers take care of it. (Aspirin, Ibuprofen.)
4 - Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours.
5 - Can't be ignored for more than 30 minutes. Mild painkillers ameliorate pain for 3-4 hours.
6 - Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (Codeine, narcotics) reduce pain for 3-4 hours.
7 - Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective.
8 - Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9 - Unable to speak. Crying out or moaning uncontrollably - near delirium.
10 - Unconscious. Pain makes you pass out.
10 + - I don't know how to use a pain scale. Please disregard this numeric information.

Body Part	Frequency	Type	Aggravating	Relieving	Pain Scale
	□Constant □Sporadic □Rare □Morning □Noon □Night	□Dull □Achy □Burning□Stabbing □Electric□Radiating □ Tight/Pulling □Other__________	□Movement □Bending □Sitting □Standing □Lying Supine □Lying Prone □Walking □Heat □Cold □Damp □Other	□Movement □Bending □Sitting □Standing □Lying Supine □Lying Prone □Walking □Heat □Cold □Damp □Medication □Other	
	□Constant □Sporadic □Rare □Morning □Noon □Night	□Dull □Achy □Burning□Stabbing □Electric□Radiating □ Tight/Pulling □Other__________	□Movement □Bending □Sitting □Standing □Lying Supine □Lying Prone □Walking □Heat □Cold □Damp □Other	□Movement □Bending □Sitting □Standing □Lying Supine □Lying Prone □Walking □Heat □Cold □Damp □Medication □Other	
	□Constant □Sporadic □Rare □Morning □Noon □Night	□Dull □Achy □Burning□Stabbing □Electric□Radiating □ Tight/Pulling □Other__________	□Movement □Bending □Sitting □Standing □Lying Supine □Lying Prone □Walking □Heat □Cold □Damp □Other	□Movement □Bending □Sitting □Standing □Lying Supine □Lying Prone □Walking □Heat □Cold □Damp □Medication □Other	
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