RICHMOND NATURAL MEDICINE
Thriving in Health

2201 West Broad Street, Suite 107
Richmond, VA 23220
T/F (804) 977-2634
www.richmondnaturalmed.com

# Confidential Client History for Medical Qigong, Reiki and Healing Touch

Name:_____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone (home): _____ cell: _____ other: _____

E-mail address: _____ Add to Mail List? ____Yes ____No

Referred by_____

## TYPE OF SESSION YOU SEEK:

Medical Qigong _____ Healing Touch _____ Reiki _____ Unsure _____

## MAIN REASON FOR SEEKING SESSION:

_____

_____

_____

_____

## LIVING SITUATION (spouse/partner, alone, pets, social supports):

_____

_____

_____

_____

## HEALTH PROFESSIONALS SEEN (mark all that apply):

| | | | | |
|---|---|---|---|---|
| Naturopathic Physician<br>Date: | Western Physician<br>Date: | Nurse Practitioner<br>Date: | Physical Therapist<br>Date: | Specialist<br>Date: |
| Chiropractor<br>Date: | Osteopath<br>Date: | Nutritionist<br>Date: | Herbalist<br>Date: | Homeopath<br>Date: |
| Acupuncturist<br>Date: | Massage Therapist<br>Date: | Other: | | |

Additional Comments: _____

_____

## SURGICAL HISTORY

Have you had any surgeries? Yes ____ No ____

If so, please list them with the year:

_____Year_____

_____Year_____

_____Year_____

_____Year_____

_____Year_____

## HEALTH HISTORY/CURRENT SYMPTOMS

For this section, please circle all that apply:

| | | | |
|---|---|---|---|
| Chronic Fatigue | Fibromyalgia | Lyme | Heart |
| Lung | Digestive Issues | Thyroid/Hormonal | Bronchitis |
| Liver | Asthma | Heart Attack | Circulation |
| Stomach | Gall Bladder | Stroke | Reproductive Organs |
| Urinary Tract | Clot | High Blood Pressure | Sexual Assault/Abuse |
| Colon | Eating Disorder | Seizures | Cancer |
| Diabetes | Vision | Kidneys | Hearing |
| Depression | Headaches | Weight Concerns | Allergies |
| Serious Accident/Trauma | Alcohol/Drug Concerns | Mental/Emotional | Adrenal Fatigue |

Other:

## MEDICATIONS/SUPPLEMENTS

Circle all that apply:

| | |
|---|---|
| Over-the-counter medication | Vitamins |
| Prescription medication | Supplements |
| Homeopathic remedies | Herbal Remedies |

## LIFESTYLE

**Do you currently use any of the below, if so what type and how often?**

Alcohol _____

Recreational drugs _____

Tobacco _____

Caffeine _____

Sugar _____

**Nutrition (describe):**

_____

_____

_____

_____

**Elimination (circle all that apply):**

Regular Constipation Diarrhea It often varies

**Water intake:**

Number of 8 oz. glasses per day _____

**Sleep patterns (circle all that apply):**

Insomnia Use sleep aids Oversleep Other: _____

**Personal Stresses – use a scale from 0 (no stress) to 10 (extreme stress) for the following:**

| | | | |
|---|---|---|---|
| Health | _____ | Work | _____ |
| Relationships | _____ | Finances | _____ |
| Loss | _____ | Other | _____ |

**Relaxation/Self Care (circle all that apply):**

Exercise/Sports Hobbies Friends/family Support groups Other: _____

**Religious/Spiritual Practices/Belief System:**

_____

_____

**Do you have any type of meditation experience? Yes _____ No _____**

Describe: _____

_____

_____

**What do you believe is the reason for your current health issues?**

_____

_____

**Is there anything else you would like to tell me?**

_____

_____

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# Payment Policy

Richmond Natural Medicine strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all procedures and products.

**Payments:** Payment for services rendered is due at the time of service. We accept cash, Visa, MasterCard, Discover and American Express. We also accept payment by check and debit cards. We hold a credit card number on file to secure your appointment and to secure necessary fees for breach of our cancellation policy. Richmond Natural Medicine will send clients accounts to collections for balances not paid after two failed attempts to collect on balances past due by 60 days or more. Payment plans are offered at management's discretion. We reserve the right to require payment for services to be made at or before the time of service.

**Outstanding balances:** We may refuse to see patients who have large balances or are not making regular payments on their balance. If you have an unpaid balance at the end of a billing cycle, we may apply a $5 late payment fee to your account. If you make a payment and it is insufficient to pay both the late payment charge and the principle amount due, we apply your payment to the late payment fee due and then we apply the remaining amount to the principal. In the event that your account is placed for collection, a collection fee will be added to your account, along with any attorney fees and/ or court costs that may be necessary for recovery of the outstanding balance. In the event of an "insufficient fund" check, there will be a $25 insufficient funds charge added to the balance due.

**Cancellations:** We charge your credit card on file if you do not call and cancel your appointment within the time frames listed below. Notification allows the practitioners to see other clients who need to be cared for that day.

**New Client and Follow-up appointments:** Follow-up appointments that are cancelled without providing a 24-hour notice will be charged a $75 insufficient notice fee, new patient appointments that are cancelled without providing a 24-hour notice will be charged a $100 insufficient notice fee. Failure to show for an appointment will also result in a charge to your credit card.

**Dependents:** You are responsible for payment of services rendered to your dependents on your account.

I authorize Richmond Natural Medicine to keep my signature on file and to charge my credit card (held in our secure system) for:
1. Charges associated with appointments that are not cancelled within the timeframes listed above.
2. Charges associated with payment arrangements. Contact management to make payment arrangements.

Attestation Statement:

I have read, understand, and agree to the above Richmond Natural Medicine Payment Policy. I understand that charges are my responsibility. I acknowledge that these policies do not obligate Richmond Natural Medicine to extend credit.

_____

Print Name of Patient

_____ _____

Signature of Patient Date

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# Notice of Privacy Practices

This notice, and the accompanying Practices Regarding Disclosure of Client Health Information, describes how health information about you may be used and disclosed, and how you can get access to your health information. Copies are given to all individuals receiving care. Please review this information carefully.

**Understanding your health record**: A record is made each time you come to Richmond Natural Medicine for a treatment or consultation. Your symptoms, the practitioner's assessment, and a plan of services are recorded. This record forms the basis for planning your care and treatment/consultation at future visits, and also serves as a means of communication among other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will assist you to ensure it is accurate and make informed decisions about who, what, when, where, and why others may be allowed access to your health information.

**Understanding your health information rights:** Your health record is the physical property of Richmond Natural Medicine, but the content is about you, and therefore belongs to you. You have the right to review or obtain a paper copy of your health record. You have the right to request restrictions, to authorize disclosure of the record to others, and be given an account of those disclosures. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

**Our responsibility:** Richmond Natural Medicine is required to maintain the privacy of your health information and to provide you with this notice of our privacy practices. We're required to follow the terms of this notice and to notify you if we are unable to grant your request to disclose or restrict disclosure of your health information to others. Richmond Natural Medicine reserves the right to change its practices and promises to make a good faith effort to notify you of any changes. Other than for the reasons described in this notice, Richmond Natural Medicine agrees not to use or disclose your health information without your consent.

**Contact information:**

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# Practices Regarding Disclosure of Client Health Information

Your health information will be routinely used for treatment/consultation, payment, and quality-monitoring, and your consent, or the opportunity to agree or object, is not required in these instances:

**Treatment/Consultation**: Information obtained by your practitioner at Richmond Natural Medicine will be entered in our record and used to plan the services provided you. Your health information may be shared with others involved in your care or providing consultation about your services. Your practitioner's own expectation and those of others involved in your care may also be recorded.

**Payment:** Your record will be used to receive payment for services rendered by Richmond Natural Medicine. A bill may be sent to either you or received directly upon services rendered.

**Quality Monitoring**: Richmond Natural Medicine will use your health information to assess the care you received and compare the outcome of your care to others. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services provided.

In addition, the following disclosures are required by law and do not require your consent:

**Food and Drug Administration (FDA)**: This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable product recalls, repairs, or replacements.

**Public Health**: This office is required by law to disclose health information to public health and/or legal authorities to avert a serious threat to health or safety, to report communicable disease, injury, or disability, or to comply with mandated reporting requirements for tracking of birth and morbidity.

**Law Enforcement**: As required under state or federal law, your health information will be disclosed to appropriate health oversight agencies, public health authorities, law enforcement officials, or attorneys: (1) In response to a valid subpoena; (2) In the event that a staff member of business associate of this office believes in good faith that one or more clients, workers, or the general public are endangered due to suspected unlawful conduct of a practitioner or violations of professional or clinical standards; (3) When a client is a suspected victim of abuse, neglect or domestic violence.

It is Richmond Natural Medicine' practice to consider the following as routine uses and disclosures for which specific authorization will not be requested. You have the right to request restrictions on these uses. Otherwise, Richmond Natural Medicine will request your authorization whenever disclosure of personal health information is necessary to parties other than those referenced here:

**Business Associates:** Some or all or your health information may be subject to disclosure through contracts for services to assist this office in providing health care. To protect your health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

**Communications with Family**: Using best judgment, a family member, close personal friend identified by you, personal representative, or other persons responsible for your care may be notified or given information about your care to assist them in enhancing your well-being or to confirm your whereabouts.

## Consent

I consent to the use or disclosure of my protected health information by RNM for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of RNM. I understand that analysis, diagnosis or treatment of me by RNM may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. RNM is not required to agree to the restrictions that I may request. However, if RNM agrees to a restriction that I request, the restriction is binding on RNM.

I have the right to revoke this consent, in writing, at any time, except to the extent that RNM has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of RNM and understand that I have a right that Notice 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of RNM. The Notice of Privacy Practices for RNM is also available at the front desk at 2201 West Broad St. Suite 107, Richmond, VA. This Notice of Privacy Practices also describes my rights and duties of RNM with respect to my protected health information.

RNM reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of RNM and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

**Signature of individual or guardian** **Date**

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# HIPAA Privacy Authorization Form

*This form is required by the Health Insurance Portability and Accountability Act (HIPAA), Section 45 C.F.R. Parts 160 and 164 Authorizatio*n

I, _____, authorize Richmond Natural Medicine (RNM) to use and disclose the protected health and demographic information to the individuals working within the establishment. Also, this authorization expires will expire one year from today's date: ____/___/___ .

**You have the following rights:**

1. I have a right to refuse sign this authorization.
2. I have a right to receive a notice about my privacy policies.
3. I have a right to request and access my medical information.
4. I have a right to limit the uses and disclosure of my medical information.
5. This medical information will only be used by the person I authorize to receive this information health care and health consultation or other purpose I may authorize.
6. I understand that I have a right to withdraw this authorization, in writing, at any time during my care. I acknowledge that a withdrawal is not effective to the extent that any person or entity has already acted in reliance on my authorization.

□ I do not give anyone (family, caregiver, friends) access to my medical information related to my care

□ I do give the following individuals access to my medical information related to my care:

Name(s): _____

Expiration of access: _____

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative

Date ____ /____ /_____