LifePoint Medical Consultants, LLC

Lisa Michele Holt DACM-BC

lifepointaom@gmail.com

719-314-9121

Welcome to Our Office

Confidential Patient Information

Date_____

Name _____

Address_____

City:_____ State_____ Zip _____

Phones - Home ( ) _____
Work ( ) _____Cell ( )_____

Email _____

Referred By:_____

Spouse Name _____ Phone ( ) _____

Age:____ Birth Date: _____ Sex: M / F Marital Status: S / M / W / D

Occupation _____

Employer & Address: _____

Guardian Name _____

Guardian's Phone No. _____

Emergency Contact Name _____

Phone No._____

Notice to Our Patients About Our Privacy Practices and Your Rights Regarding Your Health Information

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

We, at LifePoint Medical Consultants, LLC, pledge to give you the highest quality health care and to have a relationship with you that is built on trust. This trust includes our commitment to respect the privacy and confidentiality of your health information. This Notice is being given to you because federal law gives you the right to be told ahead of time about:

How we will handle your health information
Your rights concerning your health information
Our duties concerning your health information

HOW WE WILL HANDLE YOUR HEALTH INFORMATION:

Health information means information you give about yourself and your health when you become our patient. This information, along with the record of the care you receive, is your "health information." This is kept in paper form in your chart and in some cases in electronic form on the computer. We use your health information within our office and may in some cases share it with others outside our office, in order to give you excellent care. We may legally use and share your health information, without asking for your specific permission, for:

Treatment – This means how we provide and manage your health care and related services, and might include coordination of your care with other providers, to ensure that everyone caring for you has the information they need where applicable.

Payment – This means sharing your health information in order to bill and collect payment for health services we give you, where applicable.

Health Care Operations – These are activities related to the business aspects of operating LifePoint Acupuncture and Oriental Medicine and carrying out our mission and could include storing your information on computers, conducting quality assessment and improvement activities, auditing, and financial recordkeeping.

Other purposes including complying with state and federal laws and regulations, required reporting to public health and child protection authorities, for legal and administrative proceedings, law enforcement purposes, to avert a serious threat to health or safety and other permissible purposes. All those we may share your information with, must also take steps to keep your health information private. We will disclose only the minimum amount of information necessary to achieve the required purpose. We will utilize physical safeguards for your information including shredding of personal documents not in use and retaining records in a secure location. We will train all our staff to comply with this Notice and our privacy practices.

We may use your health information to contact you:
At the address and telephone numbers you give to us, including leaving messages at the telephone numbers, about scheduled or cancelled appointments, billing or payment matters, procedure assessments and test results.

With other information about care issues, treatment choices and follow-up care instructions and other health-related benefits and services that may be of interest to you.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION AND HOW TO EXERCISE THEM:

You have the right to ask for restrictions on the use and sharing of your health information for treatment, payment or health care operations, including restrictions on using this information to notify you about appointments, etc. For example, you may ask that we not contact you with appointment reminders by telephone, or only call at you work or cell telephone number rather than home. When we ask you to provide us with information necessary for contacting you, it is your responsibility to do so and to make sure the information is accurate and current. We are not required to agree to your request for restrictions but will make reasonable efforts to honor reasonable requests. You may not ask us to restrict uses and sharing of information that we are legally obligated to make.
You have the right to look at and get a copy of the health information that we keep of your medical treatment and bills. You must ask for this in writing. We will respond within thirty (30) days. If you ask for a copy of your records, you will be charged a fee. If we deny your request, we will explain the reasons in writing and tell you what rights you have, if any, to a review of the denial.
You have the right to ask us to change your health information relating to your treatment and bills if you think there has been a mistake or information is missing. You must make this request in writing and give the reason you want the change. We have 60 days to respond to your request, and a 30-day extension after with notice to you of why we need the extension and when you may expect a response. We may deny your request, and if so must provide you with a written statement with the reasons for the denial and what other steps are available to you.
You have the right to get a record of the times that your health information was shared, upon written request, except when the sharing was for treatment, payment or health care operations, or if you gave permission, or the sharing was with persons involved in your care or with you about your health care, or when the law required us to share the information. You may request this as far back as April 14, 2003.
The list you will get will include the date, name, address, if known of the person who received the information, a brief description of the information given and statement of why the information was shared. We have 60 days to respond to your request and are allowed a 30-day extension upon notice to you including the reasons for the extension and date you may expect the information. You are entitled to one free request in any 12-month period. You have the right to ask for a paper copy of this Notice from the contact listed at the end of this Notice.

OUR DUTIES CONCERNING YOUR HEALTH INFORMATION:

We are required by law to keep your health information private. We are required to give people notice of our legal duties and privacy practices concerning your health information. We must abide by the terms of the Notice currently in effect. We reserve the right to change our privacy

practices and the terms of this Notice at any time. If so, the updated Notice will be posted in our office and on our website for public inspection.

HOW TO SUBMIT A COMPLAINT IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED:

If you think we may have violated your privacy rights or you disagree with any action we have taken with regard to your health information we want you, your family or your guardian to speak with us. If you complain to us, your care will not be affected in any way. It is our goal to give you the best care while respecting your privacy.
You may file a complaint by contacting any member of our staff. You may also send a written complaint to the U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, DC 20201, (202) 619-0257, Toll Free: 1-877-696-6775. We will take no retaliatory actions against you if you file a complaint about our privacy practices.

EFFECTIVE DATE OF THIS NOTICE: This notice is effective January 1, 2021.
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I acknowledge that I have been given a copy of this Privacy Notice and have been given an opportunity to review it and ask any questions I might have about it and what it means to me.

Patient or Representative Name (Please Print) _____

Patient or Representative Signature _____

Date: _____

FINANCIAL & CANCELLATION POLICY

Payment is expected in full at the time of service unless other arrangements have been made with the office. We do work with insurance companies, however, we will need complete verification of your policy's coverage before we will accept insurance for payment. Until such time, the patient will be expected to pay all charges in full at the time of your visit.

When you make an appointment with our office, you are reserving time to work on your health needs. If you find that you are unable to make it to your appointment and need to cancel or reschedule, we ask that you give no less than 24 hours advance notice. We often have a list of patients waiting for cancellations to schedule appointments, and with sufficient notice from you we can fill your spot. Accordingly, you will be charged for the appointment if you give less than the required 24-hour notice.
Please note that if you are more than 15 minutes late for your appointment, you will have to reschedule it for a later time and the cancellation policy will apply.

We understand that emergencies arise and will consider these on a case-by-case basis.

By signing this form, you, the Patient, acknowledge that you have read and agree to our Financial and Cancellation Policy.

_____ Date: _____
Signature of Patient

Authorization to Call or Leave Messages

In accordance with HIPAA regulations, we at LifePoint Medical Consultants, LLC, need to know in writing what phone number(s) we may call to speak with you or to leave a message. Most calls will be regarding scheduling, however, an occasional call may be regarding your condition. Below are commonly used phone types, with spaces for you to provide the number. Please provide only those numbers that we have permission to use.

Patient Name: _____

My home: _____

My work: _____

My cell: _____

The best number to reach me at in case of last-minute scheduling changes or other reason is my ( ) Home; ( ) Work; ( ) Cell (Please check one)

If you cannot reach me at the above numbers, please contact:

Name: _____ Relationship: _____

Home #: _____

Work #: _____

Cell #: _____

General Medical Records Release

Patient Name: _____

Address: _____

Phone: _____

SSN: _____Date of Birth:_____/_____/_____

I authorize the custodian of records of:

_____

to disclose/release all medical records to:

LifePoint Medical Consultants, LLC
Phone: (719) 314-9121

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I understand this authorization is voluntary and that I may refuse to sign this authorization. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____
Signature of patient (or personal representative) Date

Medical Questionnaire

Birth Date:

Sex:

Family Health Physician (s):

Main Reason For your visit today: _____

_____

_____

Please list **Surgeries** (type of surgery and date). Include major **dental** work. _____

_____

_____

_____

_____

Please list all **Medications** _____

_____

_____

_____

Please list **Accidents or Falls** (type and date) _____

_____

Other Doctors you have seen for this condition

_____

_____

Any additional information or remarks _____

_____

_____

_____

Other Information

Height _____ Weight (Now) _____ (One year ago) _____

Allergies

_____

_____

_____

Exercise and sports

_____

_____

Life-style Habits

_____

_____

Family History:

Alcoholism	Allergies
Cancer	Diabetes
Epilepsy	Heart disease
High blood pressure	Stroke
Other:	Details:

Personal History:

Accidents, injuries, traumas	Allergies
Cancer	Diabetes
Epilepsy	Hypertension
Hyperactive thyroid	Hypoactive thyroid
Joint diseases	Low blood pressure
Medications in use	Scars
Surgeries	Other:
Details:	

General Info:

A need to sleep a lot	Cold abdomen or back	Cold limbs
Disturbing dreams/nightmares	Excessive perspiration	Extreme thirst
Fainting	Fatigue	Hormonal disorders
Insomnia	Lack of perspiration	Lack of thirst
Light sleep	Perspires easily	Preference for cold drinks
Preference for warm drinks	Restless sleep	Sensitivity to weather changes
Shivers, chills	Other:	Details:

Hair / Skin:

Acne/pimples	Allergies
Brittle hair/nails	Dandruff
Dry scalp	Eczema
Hair loss	Hematomas
Itchiness	Oily skin
Psoriasis	Skin rashes
Other:	Details:

Head / Neck:

Bad breath	Bleeding from gums	Bleeding from nose
Blurred or weak vision	Cataract	Dizziness
Dry eyes	Dry mouth	Dry throat
Ear aches	Floaters in the vision	Gingivitis
Glaucoma	Headaches, migraines	Hearing disorders

Hoarseness	Itchy eyes	Low humming in ears/tinnitus
Night blindness	Otitis/ear infection	Pressure in head or behind the eyes
Red eyes	Sinusitis	Sore throat
Stuffiness in the head	Stuffy nose	Swollen glands in the neck
Teeth grinding	Tongue/ mouth ulcers	Other:
Details:		

Heart / Blood Vessels:

Arrhythmia	Catheterization
Chest pains	Edemas
Heart surgeries	Hypertension
Low blood pressure	Palpitations
Thrombus/blood coagulation	Varicose veins
Other:	Details:

Lungs / Breath:

Asthma	Bronchitis	Chronic cough
Chronic runny nose	Cough with white phlegm	Cough with yellow phlegm
Dry coughing	Dry mucus membranes	Frequent colds
Heavy breathing	Phlegm/sputum	Pneumonia
Sensitivity to cold	Sensitivity to dryness	Sensitivity to heat
Sensitivity to humidity	Sensitivity to wind	Shortness of breath
Sneezing	Snoring	Wheezing
Other:	Details:	

Digestion System:

Appetite deficiency	Belching/hiccups
Hematuria	Constipation
Craving for bitter foods	Craving for salty foods
Craving for sour foods	Craving for sweet foods
Diarrhea	Excessive appetite
Flatulence, bloating	Frequent bowel movements per day/#
Heartburn	Hemorrhoids/piles
Nausea	Prolapse of stomach/intestine
Stomachaches	Vomiting
Weird tastes	Other:
Details:	

Urinary System:

A burning sensation when urinating	Dark colored urine
Difficulty in urination	Dribbling after urination
Excessive urination	Incontinence
Light colored urine	Nocturnal urination
Prolapse of urinary bladder	Scanty urination
Urinary frequency/#	Urinary urgency
Other:	Details:

Skeletal / Muscles:

Heaviness of limbs	Joint diseases
Joint pains	Lower back pains
Middle back pains	Muscle cramps, pains
Numbness of limbs	Osteoporosis
Spinal column disorders	Tense neck
Tense shoulders	Tingling of limbs
Upper back pains	Weakness in back
Weakness in limbs	Weakness in muscles
Weakness in neck	Weakness in shoulders
Other:	Details:

Neuro Psychology:

Anger	Anxiety
Apathy	Depression
Difficulty in focusing, concentrating	Easily irritated
Excessive worrying/easily worried	Fears Insecurity
Mood swings	Nervousness
Oversensitivity	Sadness
Sighs	Stress
Suicidal thoughts	Psychiatric medicines:
Other:	Details:

Woman:

Abridged menstruation	Bleeding in between the menstruations	Blood clots during menstruation
Brown blood	Burning sensation of genital organs	Contraceptives
Dark blood	Date of last gynecology checkup	Diminished libido
Excessive blood during menstruation	Extended menstruation	Hot flashes
Intermission of menstruation	Irregular menstruation	Decreased amount of blood during menstruation
Light/pale red blood	Menopause	Mood swings before menstruation
Number of babies	Number of days during menstruation	Number of miscarriages
Number of pregnancies	Painful menstruation	Post menstrual pains
Premenstrual pains/soreness (PMS)	Prolapse of uterus	Prolapse of vagina
Sexually-related disorders	Vaginal discharges	Vaginal infections
Other:	Details:	

Man:

Diminished libido	Genital discharge
Genital pains	Impotence
Increased libido	Nocturnal emission
Nocturnal urination	Premature ejaculation

Prostate disorders	Sexually related disorders
Other:	Details:

Please describe all other complaints you may have here. Write as detailed as you are able to.

Nutrition / Activity:

Daily intake

_____
_____
_____
_____
_____
_____
_____

In-Between meals

_____
_____
_____
_____
_____

Daily physical activity

_____
_____
_____
_____

Addictive drugs_____

Alcohol_____

Coffee-number of cups a day_____

Excessive amount of salt_____

Excessive amount of sugar _____

Smoking-number of cigarettes a day_____

Soft drinks-number of glasses a day_____

Other:

Details: