Auricular Therapy Intake Form

Welcome! I would like to make your session as pleasant and as comfortable as possible. If at any time during the treatment you have questions, please let me know.

Patient Name: _____ Age: ____ Date of Birth: ___/___/___ Gender: _____

Address:_____

City: _____ State:_____Zip: _____

Cell: _____ Work: _____ Home: _____

Email Address:_____

Occupation: _____

Referral Source: _____

Who is your primary health care provider/MD? _____

Emergency Contact: _____Phone: _____

Main Complaint *(Please identify your major health concerns)*

1. _____

   _____

   How long have you had this problem? _____

2. _____

   _____

   How long have you had this problem? _____

Personal Medical History *(Please include your childhood history)*

Do have a history of current or past infectious disease? Please describe	
Medicines (please list all medications, herbs, vitamins and over the counter drugs)	
Allergies/Sensitivities (Please list any foods, drugs, medications or environmental factors which you are sensitive or allergic to)	

Total Health Guidance, LLC. – Disclosure Statement

Thank you for deciding to seek out treatment at Total Health Guidance. We have listed below our various policies for your information. Please read through these, ask any questions, and sign at the bottom. You may call (321) 332-6984 regarding any questions you may have. All of the therapists at THG are licensed through the State of Florida and/or the Florida Association of Christian Counselors & Therapists. Total Health Guidance is not a 24 hour treatment center. In an emergency, please call 911.

We have been trained in a variety of acupuncture techniques. We will work with you to verify which techniques might be most effective for your particular needs. You may, at any time, seek a second opinion from another therapist and/or you may terminate our services at any time without penalty.

SESSIONS
Auricular therapy sessions are typically scheduled for **30-45 minutes** at a frequency to be determined by the acupuncturist and client.

PAYMENT POLICY
We see clients on a fee-for-service basis only. The client/parent is responsible for payment in full at the time of each session. Fees for auricular therapy sessions are **$40** for a 45 minute auricular therapy session. Additional time options and cost can be established with the therapist. Our policy is for each person to pay for services at the time they are rendered. Any other arrangements must be made in advance. A $25 administrative fee will be charged on all checks that are returned for non-sufficient funds. Payments can be made by cash, check or credit card. Charges for testing services are an additional fee.

INSURANCE
Please direct questions about reimbursement amounts and timeliness to your insurance company. We can provide you with a receipt for the acupuncture service that may be used to submit for reimbursements if you choose. We do not complete any insurance paperwork. If you elect to use your health insurance plan to assist in the payment of treatment then you understand that your insurance carrier and the National Information Center will have access to your diagnosis code and other pertinent data needed for processing.

CANCELLATIONS
We understand that it may, at times, be necessary to cancel an appointment. We require that **changes / cancellations be made 24 hours in advance.** Any changes, cancellations, or missed appointments within the 24 hour period **will result in a $40 cancellation charge.**

CONFIDENTIALITY
The confidentiality of the services provided by us is protected by law. Unless you grant us permission to do so in writing, we will neither inform anyone that you are a client, nor will we disclose the content of any session. The only circumstances under such professional confidentiality may be broken is if one or more of the following conditions apply:

If you pose a serious physical danger to yourself or to another person,
If you disclose that you or another person has physically or sexually abused or molested a child, an incompetent or disabled person, or
If you disclose that a child, an incompetent or a disabled person is suffering because of neglect.

If such abuse or neglect is disclosed, we are mandated by Florida law to report such information to an appropriate state agency.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT
I have read the preceding information and agree to it. I authorize treatment of the person named below and agree to pay all fees. I have received a copy of our HIPAA Notice of Privacy Rights.

_____	_____	$_____
Signature of Client or Legal Guardian	Signature of Acupuncture Physician	Agreed Upon Rate per Session
_____	_____	
Date	Date	