GRD Health Center

Intake Form

Date:_____

Patient's name:_____ Legal name:_____

Male___ Female___ Age:_____ Birth date:_____ Social Security number:_____

Single___ Married___ Divorced___ Separated___ Widowed___ Driver's License number:_____

Home phone number:_____ Work Number:_____

Cell number:_____ E-mail:_____

Home address: _____

Employer: _____ How long _____ Occupation_____

Who referred you to our office _____

In the case of an emergency, whom should we contact? _____Relation _____ Phone_____

Main Complaints: What brought you to our office, how long has it been going on?

1. _____
2. _____
3. _____

Minor Complaints: List other symptoms that we may be able to help you with.

1. _____
2. _____
3. _____

Major Illness in the past: Please state the type of illness and your approximate age at the time of illness.

1. _____ 2. _____

Allergies:

_____ _____

Surgeries:

_____ _____

Prescription medicine: Please state the medication and reason for taking it.

_____ _____

_____ _____

List prescription medicine that you have taken a lot of in the past and for what it was used.

_____ _____

Are you currently taking any herbs or food supplements?

_____

How much and why?

_____

When was your last X-ray taken? _____

205 Los Alamos Hwy, Ste C Espanola, New Mexico 87532 505.753.3369 Fax 505.753.4006

For Women:

Are you taking birth control pills? _____ Are you currently pregnant? _____

If pregnant, how long? _____ Are you currently nursing? _____

If there are any changes, please notify doctor immediately.

Do you have any difficulty with your monthly cycle? Cramping, back pains, fatigue, blood clots, headaches?

_____

Family history:

Please list only the serious illnesses of you relatives. If your relative is deceased, please state the cause of death if you know it, along with the serious illness suffered while alive.

Mother: _____ Father: _____

Mother's Parents: _____ Father's parents: _____

Brothers and Sisters: _____ Children: _____

Stress levels:

Please use numbers to indicate stress level (1- low, 2- medium, 3- high, 4- varies)

Work ____ Finances: ____ Home Life ____ Primary Relationship _____

Other: _____ Describe _____

Drug, Alcohol, and Caffeine Use:

Did you drink alcohol on a regular basis? _____ If so, when and for how long? _____

Did you ever use non-prescription drugs? If so, which specific drugs, when and for how long a period of time?

_____

Do you drink cokes or coffee? _____ if so, how much per day? _____

Do you smoke?_____ How much?_____ For how long?_____

Diet:

What have you eaten in the past 24 hours? _____

What is a typical:

Breakfast _____

Lunch _____

Dinner _____

Do you shop at a health food store?_____ Are you interested in making changes in this area? Yes___ No___

Exercise:

Do you have any regular exercise program? Yes _____ No _____

What is it? _____

What exercise have you had in the past week? _____

Weather:

Does the weather seem to affect you or your symptoms? Yes___ No ___ Sometimes___ Not sure _____

Please explain exactly how you were affected. _____

This weather usually bothers me (Yes, No, Sometimes):

Windy ____ Cold _____ Hot ____ Humid & Hot ____ Damp & cold ___ Rapid Changes in Weather ____

Change of Season _____ In general, do you feel hot or cold? _____

Emotions:

In the past few months, have you experienced any of these emotions more often than others?

1-Often, 2-Sometimes, 3-Seldom

____Anger ____Sadness ____Grief or sorrow ____Fear ____Anxiety ____Worry

Other: Is there anything you would like to add about your emotional or mental state or your temperament?

_____

205 Los Alamos Hwy, Ste C Espanola, New Mexico 87532 505.753.3369 Fax 505.753.4006

Policies

- ☐ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered in this office. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting you account.
- ☐ We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- ☐ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and/or managed care organization to release any information required to process insurance claims.
- ☐ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Please Sign Here : _____ **Date:** _____

Patient's Statement of Privacy Rights

As a patient of this practice, you have the right to privacy of your Personal Health Information, and to know that such information shall be properly and securely maintained by this practice, in accordance with our own policy and in compliance with the Health Information Accountability and Portability Act of 1996 (HIPAA). HIPAA was enacted to give you, the patient of a health care provider and covered under a health insurance claim, more control over your health information, to set boundaries on the use and release of health records, establish appropriate safeguards that Personal Health Information, and to hold violators accountable, with appropriate penalties for violation of a patient's right to privacy.

AS A PATIENT OF THIS PRACTICE:

1. You are entitled to an individually delivered, written notification of your Privacy Rights at the time of your first visit to this practice's facility. The document you are reading is this notice.
2. You are entitled to see your medical records.
3. You are entitled to receive a copy of your medical records. (Forms are available upon request.)
4. You are entitled to make an amendment to your patient health information within those records. (Forms are available upon request.)
5. While the doctor has a right to deny inclusion of amendments into a patient file, you have the right to disagree with the doctor's refusal of such inclusion of amendment to those records. (Forms are available upon request.) If the doctor disagrees, he shall supply you with written notification of such disagreement.
6. The doctor has a right to a rebuttal to the patient's disagreement. But any time a file is sent out of the office, a copy of that rebuttal must be included in the file.
7. You have the right to specify how access to your health information is restricted and from whom.
8. You have the right to indicate the method and/or phone numbers and/or addresses to which telephonic and written communications to you shall be forwarded.
9. All covered entities under HIPAA, such as this practice or other health care providers, or business associates such as billing companies or claims administrators, as are designated by the HIPAA Privacy Rule, and with whom this practice must work on your behalf from the standpoint of effective treatment or billing of medical services and administration of such services, shall be a part of a "Chain of trust" under applicable Business Associate Agreements whenever applicable with those parties. This means that those parties are bound to maintain the same privacy and security of your health information, as are we.
10. No personal health information shall be given out to any entity not related to your treatment and the billing of medical services rendered, without your written authorization.
11. You are entitled to this practice's best efforts to maintain the security of Personal Health Information on your behalf within and outside this office.
12. This practice shall provide Personal Health Information to required parties on the basis of the minimum necessary standard of release (releasing only that information necessary for those parties to provide treatment, reimbursement, or administrative services on your behalf), and so as to maintain the intent of HIPAA in establishing that standard.
13. You have the right to inquire of this office and gain correct and appropriate answers to any questions regarding your privacy rights at any time, consistent with those rights as covered by HIPAA.
14. You have the right to contact the Department of Health and Human Services, Office of Civil Rights, which administrates HIPAA, with questions or to file a complaint. Toll Free: 1-877-696-6775 or internet: www.hhs/gov/ocr.

Patients Affirmation of Receipt of Patients Statement of Privacy Rights

I hereby acknowledge receipt of this office's Statement of Privacy Rights, provided on my behalf and in accordance with the law, and have read and understand my rights to privacy and security of Personal Health Information, as patient of this practice.

Please Sign Here : _____ **Date:** _____

GRD Health Cente
Shakti Health Inc
205 Los Alamos Hwy, Ste
Espanola, NM 8753
(505)753-336

FINANCIAL POLICY

Please read our financial policy and indicate your agreement by your signature. We are committed to providing you with the best possible care and we are please to discuss our professional fees with you at any time. You clear understanding of our financial policy is important to our professional relationship. If you have any questions, please do not hesitate to ask.

FULL PAYMENT IS DUE AT TIME OF SERVICE

We accept cash, checks and credit cards.

If you would like us to bill your insurance, we will contact your insurance and bill them based upon the non-guaranteed information they provide us.

You are responsible for all co-payments, deductibles and other adjustments made by your insurer. There may be an additional charge not covered by your insurance plan that you will be responsible to pay.

Insurance companies may reimburse differently than the information they originally provide to us. You are responsible for and will be billed for any resulting unpaid balance.

Thank you for your courtesy and understanding. If you have any questions or concerns, please feel free to discuss them with th Office Manager

CANCELLATION POLICY AGREEMENT
For Massage Therapy Treatments

GRD Health Center is committed to providing all of our patients with exceptional care. We understand that situations arise in which you must cancel your appointment. We request if you must cancel your appointment, please provide 24 hours of notice. To cancel a Monday appointment, please call our office on Saturday before 12:00pm.

Patients who are not able to keep their appointments are required to give our office 24 business hours cancellation notice o there will be a $50 fee. This fee is NOT covered by insurance.

GRD Health requires that a credit card be kept on file. If you do not cancel your appointment within the required 24-hour notic period, you authorize GRD Health to charge , to this card.

Visa, Mastercard, Discover number: _____

Name on card: _____

Exp date: _____ Sec code: _____

Authorized signature: _____

GRD Health reserves the right to terminate the doctor/patient relationship for lack of payment for any reason.

Please sign below to consent to these terms

_____ Date____/____/____
Client Signature (Client's Parent/Guardian if under 18)

Shakti Health Inc.
GRD Health Center
Dr. Jiwan S. K. Khalsa, D.O.M.
510 N. Paseo de Onate Espanola, NM 87532
(505) 753-3369

Informed Consent to Health Care by a Doctor of Oriental Medicine

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Dr. Jiwan Shakti K. Khalsa and or other licensed doctors of oriental medicine who now or in the future treat me while employed by, working or associated with or serving as back-up for medical procedures including diagnostic techniques such as questioning, pulse evaluation, acupuncture, injection therapy, palpation on a variety of areas of my body, observation, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as massage, manipulation of joints and/or viscera, heat and or cold therapy and electrical and/or magnetic stimulation: the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendation: exercise advice and healthy lifestyle counseling.

I have had an opportunity to discuss with my Doctor and/or with other clinic personnel the nature and purpose of acupuncture, oriental medical procedures and injection therapy. Although I am aware that acupuncture and the other procedures used in oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of allopathic medicine, in the practice of oriental medicine and injection therapy there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible I understand that these risks include but are not limited to: bleeding, bruising, pneumothorax (punctured lung), puncture of other organs, pain or other strong sensation at the location where a needle is inserted or radiating from that location, nerve pain, burns, infection, aggravation of current symptoms, appearance of new symptoms, general aches, sprains, strains, dislocation, fractures, disc injuries and strokes. I understand that there are risks associated with acupuncture when pregnant, such as abdominal cramps and possible miscarriage, if I am pregnant I have informed the doctor and I accept responsibility for the outcome of the treatment. I understand that joint regenerating injections work by creating mild inflammation, but on rare occasion there can be stronger inflammatory responses for some days after injection. I understand that infection is possible with any needling, yet it is extremely rare. I understand that herbs, supplements, other oral/injected medicines, or even recommended natural foods can cause strong allergic or other reactions, even dangerous or deadly ones, though such reactions are very rare. I will always retain the right to accept or reject any diagnostic procedure or any treatment, before or during any procedure. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise such judgment, during the course of my treatments, as the doctor feels at the time, based on the facts then known, to be in my best interest.

I have read, or have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment form Dr.(s) Khalsa.

Patient's Name (Print)_____Patient's Signature _____Date___
Witness_____
Printed name of Patient's Representative (if applicable)_____
Signature of Patient's Representative (if applicable)_____
Relationship or Authority of Patient's Representative_____

Sleep:

Do you have any problems with sleep? Yes ___ No___ Do you experience night sweats? Yes ___ No___
If yes, please describe in some detail (for example, difficulty falling asleep, or, if I fall asleep okay but wake up an hour later and cannot get back to sleep, or I get up several times a night to go to the bathroom, etc.)

Digestion:

Do you have any problems with digestion? Yes ___ No ____
If yes, please describe (i.e.: lack of appetite, a lot of gas, bloating, constipation, abdominal pain, etc.)

Respiration:

Do you have any difficulty breathing? Yes ___ No ___
If yes, please describe in some detail (for example, I am allergic to cats, I have asthma, I get short of breath upon exertion, etc.)

Elimination:

Do you have any problems with urination? Yes _____ No _____
If yes, please describe in some detail (for example, frequent urination, night urination, difficulty urinating, frequent bladder infections, etc.)

Do you have difficulty with bowel movements? Yes ____ No ____
If yes, please explain (difficulty with constipation, diarrhea, both, blood or mucous in stool, etc.)

Energy level:

Do you have any problems with fatigue? Yes ___ No ___ How long: _____
If yes, pleases describe in some detail (for example: tired upon waking, getting exhausted after eating or exercising, exhaustion after sexual activity, late afternoon fatigue)

Does anything help you? (Rest, exercise, eating less, etc.) _____
Do you get headaches? Yes___No___ If so, how often? _____

Rest and Relaxation:

What do you like to do for rest and relaxation? _____
Have you done it in the past week? _____How often do you do it? _____

Other Therapists:

Are you currently seeing any other health practitioners? Yes ____ No ____
If yes, please list them, what their specialty is and why are they treating you:

Is there anything else you would like to tell me that might help me serve you better?

What do you think is the major cause(s) of your health problems?