Unveiling Wellness LLC

Dr. Saima Bhatti OM
www.SaltRoomOrlando.com

Confidential Health History Questionnaire Date:_____

I look forward to helping you achieve your health goals. Please help me learn more about you so that I may provide you with the most effective care. On this questionnaire, you will find many in-depth questions; each answer provides important information that allows me to optimize your health care results. Thank you for your thorough responses.

Last Name	First Name	Middle Initial	Social Security #

Street Address	City	State	Zip

Home Phone	Cell Phone	Date of Birth	Age	Sex	Marital Status

Work Phone	Employer & Occupation	Emergency Contact: Name & Phone

Height	Weight	Blood Pressure	Date of BP Reading	Blood Type

E-mail Address (for articles and newsletters)	How did you hear about us?

Are you currently under a Medical Doctor's care?	MD's Name	MD's Phone

List your reasons for today's visit, in order of importance.

What treatments have you tried or are you currently doing for these conditions?

Check if you have a FAMILY HISTORY of any of these:

• Allergies	☐ Diabetes	☐ Kidney disease
• Arthritis	☐ Epilepsy / Seizures	☐ Mental illness
• Asthma	☐ Glaucoma	☐ Stroke
• Bleeding disorders	☐ Heart disease	☐ Thyroid disease
• Cancer	☐ High blood pressure	☐ Other inheritable disease _____

Please identify current symptoms by marking the box under the "Now" column.
Mark the "Past" column only if a past condition was particularly severe or significant.

Past	Now		Past	Now		Past	Now	
□	□	Abdominal / stomach pain	□	□	Chills	□	□	Anger
□	□	Abnormal appetite	□	□	Fever	□	□	Anxiety
□	□	Nausea / vomiting	□	□	Excessive sweating	□	□	Depression
□	□	Belching	□	□	Lack of perspiration	□	□	Fear
□	□	Heartburn / reflux	□	□	Hot flashes	□	□	Frustration
□	□	Gas	□	□	Night sweats	□	□	Grief or sadness
□	□	Constipation	□	□	Cold Hands/Feet/Nose	□	□	Irritability
□	□	Diarrhea	□	□	Tendency to be too hot	□	□	Mood swings
□	□	Black stool	□	□	Tendency to be too cold	□	□	Obsession
□	□	Blood in stool				□	□	Panic Attacks
□	□	Mucous in stool	□	□	Dry eyes	□	□	Stress
□	□	Undigested food in stool	□	□	Eye pain	□	□	Worry
□	□	Rectal pain / hemorrhoids	□	□	Itchy eyes			
□	□	Regular laxative use	□	□	Tearing eyes	□	□	Victim of Child Abuse
□	□	Unusually thirsty	□	□	Poor vision	□	□	Victim of Domestic Abuse
□	□	Overweight	□	□	Night or color blindness	□	□	Victim of Sexual Abuse
□	□	Weight changes	□	□	Earaches	□	□	War Veteran
			□	□	Ringing or sounds in ears			
□	□	Bleeding / bruising easily	□	□	Hearing problems	□	□	Acne pimples
□	□	Bleeding gums	□	□	Sinus problems	□	□	Dry skin / Oily Skin
□	□	Poor circulation	□	□	Sneezing	□	□	Itching or burning skin
□	□	Dizzy spells or fainting	□	□	Snoring	□	□	Skin rash or sores
□	□	Chest pain / pressure	□	□	Nose bleeds	□	□	Tendency to get hives
□	□	Irregular heart beat	□	□	Dry mouth or throat	□	□	Scalp itching or flaking
□	□	Palpitations / chest fluttering	□	□	Sore throat	□	□	Early graying of hair
□	□	Pounding heart beat	□	□	Swollen glands	□	□	Loss of hair
□	□	Racing heart beat	□	□	Frequent hoarseness	□	□	Nail fungus
			□	□	Mouth or lip sores	□	□	Weak / brittle nails
□	□	Chronic cough	□	□	Many cavities or root canals			
□	□	Coughing blood	□	□	Unusual taste in mouth	□	□	Numbness or tingling
□	□	Frequent chest colds	□	□	Teeth grinding or clenching	□	□	Poor concentration
□	□	Shortness of breath	□	□	Jaw Problems or TMJ	□	□	Poor memory
□	□	Tightness of chest	□	□	Facial pain	□	□	Seizures or convulsions
□	□	Wheezing	□	□	Headaches	□	□	Shaking or trembling
□	□	Coughing up Phlegm				□	□	Stuttering or stammering
		Color of Phlegm_____	□	□	Blood in urine			
□	□	Chronic or recurrent infection	□	□	Burning or painful urination	□	□	Difficulty falling asleep
□	□	Fatigue or tiredness	□	□	Difficult urination / retention	□	□	Waking up frequently
□	□	Sudden energy drop at _____	□	□	Frequent or urgent urination	□	□	Wake up still tired
□	□	Frequent antibiotic use	□	□	Frequent urination at night	□	□	Many dreams
			□	□	Loss of bladder control	□	□	Nightmares

LIFESTYLE & DIET

□ Tobacco □ Marijuana □ Other _____	□ Other Recreational Drugs □ High Stress □ Occupational Hazards	Exercise: (describe)
□ Coffee □ Soft Drinks □ Energy Drinks □ Sugar □ Fast Food □ Alcohol (amt):_____	□ Artificial Sweeteners □ Vegetarian/ Vegan (circle one) □ Low Carb □ Low Fat □ Paleo/Atkins (circle one) □ Crave Sugar □ Crave Salt	Herbs/Vitamins/Supplements: (list)

FOR MEN

Past	Now		Past	Now	
□	□	Genital pain, swelling or itching	□	□	Low sperm count / motility / morphology
□	□	Abnormal sex drive [high] [low]	□	□	Penile discharge
□	□	Erectile dysfunction	□	□	Prostate problem (PSA:_____)

FOR WOMEN

Past	Now		Past	Now		Past	Now	
□	□	Abnormal PAP smear	□	□	Endometriosis	□	□	Ovaries removed
□	□	Abnormal sex drive [high] [low]	□	□	Fibroids	□	□	Pain with intercourse
□	□	Abortion history	□	□	Genital pain, swelling or itching	□	□	Painful periods
□	□	Bleeding between periods	□	□	Heavy bleeding with periods	□	□	Pelvic inflammatory disease
□	□	Breast lumps / tenderness	□	□	Hysterectomy	□	□	Polycystic ovary disease
□	□	Clots in menstrual blood	□	□	Menopausal symptoms	□	□	Premenstrual tension / PMS
□	□	Difficulty conceiving	□	□	Miscarriage	□	□	Vaginal discharge or dryness

Are you currently pregnant or trying to become pregnant?

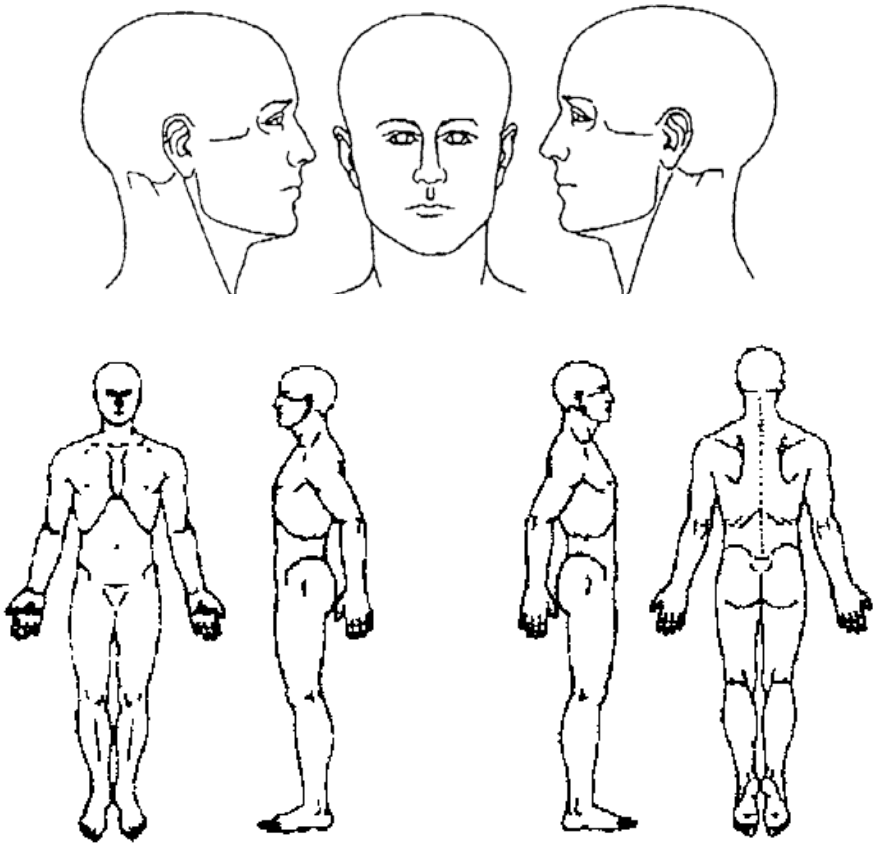
Full length of cycle (onset to onset):	Number of pregnancies you've had:
Duration of periods:	Number of births you've had:
Date last period began (day 1):	Ages of your children:
Past birth control methods:	Current birth control method:

Check if you have or had any of these:

Past	Now		Past	Now		Past	Now	
□	□	Addiction (to_____)	□	□	Fibromyalgia	□	□	Multiple sclerosis
□	□	AIDS / HIV	□	□	Gall bladder disease / stones	□	□	Osteoporosis / osteopenia
□	□	Allergies	□	□	Glaucoma	□	□	Pacemaker
□	□	Anemia	□	□	Gout	□	□	Parkinson's
□	□	Arthritis	□	□	Gum disease	□	□	Pneumonia
□	□	Asthma	□	□	Heart disease	□	□	Polio
□	□	Bleeding disorder	□	□	Hepatitis or jaundice	□	□	Rheumatic or Scarlet fever
□	□	Blood clots	□	□	Herpes	□	□	Shingles
□	□	Bronchitis	□	□	High / Low BP (circle one)	□	□	Spinal meningitis
□	□	Cancer / tumor	□	□	High cholesterol	□	□	Stroke
□	□	Cataracts	□	□	Kidney stones	□	□	Tuberculosis
□	□	Chicken pox	□	□	Kidney or bladder infection	□	□	Thyroid trouble or goiter
□	□	Chronic fatigue syndrome	□	□	Liver disease	□	□	Ulcer
□	□	Colon / bowel disease	□	□	Lupus	□	□	Varicose veins
□	□	Diabetes	□	□	Malaria	□	□	Venereal disease
□	□	Emotional / mental illness	□	□	Measles, Mumps or Rubella	Other:		
□	□	Emphysema	□	□	Mononucleosis			

Surgeries, hospitalizations & dates:	Accidents, injuries & dates:	Medications, reasons & dosages:
		_____ _____ _____ _____ _____ _____ _____

Please Indicate Areas of Pain or Discomfort:



	Severity		Severity
☐ Back pain or trouble	1 2 3 4 5	☐ Spinal disc problems	1 2 3 4 5
☐ Muscle pain, spasm, cramping	1 2 3 4 5	☐ Stiff or painful neck	1 2 3 4 5
☐ Muscle weakness	1 2 3 4 5	☐ Swelling	1 2 3 4 5
☐ Restless or nervous legs	1 2 3 4 5	☐ Tendonitis (where:_____)	

Please describe your pain/discomfort:

_____

_____

_____

_____

_____

By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I also understand that if I wish to change the dosages of my medications, Dr. Bhatti recommends that this happen gradually and with consent of my primary medical doctor.

Sign:	**Date:**

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Uses and Disclosures

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.
Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of Unveiling Wellness LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.
Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections to facilitate law-enforcement investigations and to comply with government mandated reporting.
Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that had occurred before you notified us of your decision to revoke your authorization.
Appointment Reminders: Your health information will be used by our staff to send you appointment reminders.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Unveiling Wellness LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Director or your physician directly. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:
info@saltroomorlando.com

Saima Bhatti AP, DOM
1804 North Mills Ave. Orlando, FL 32803 | (407)965-3065

Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who may now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, tui-na (Oriental massage), oriental herbal medicine, homeopathy, and nutritional counseling. I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxabustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. 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.

(Date)

PATIENT SIGNATURE:
(or patient guardian-) _____
(-indicate relationship-)

(Date)

OFFICE SIGNATURE:_____

Saima Bhatti AP, DOM

FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time you choose to change your billing option, you are required to let us know immediately and sign a new form.

_____ Insurance Billing

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check out for today's visit, and every visit hereafter. Unveiling Wellness LLC will submit my claim for me to my insurance company. Although Unveiling Wellness LLC verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co-insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are **my responsibility**. I understand that if these patient portions due are unpaid for over **90 days**, the balance can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Saima Bhatti. I also authorize the doctor to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

_____ Private Pay

Private pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to the published rate if you pay at the time of service.**

Payment Methods Accepted: Cash, Check, Visa, Mastercard, Discover and Debit Cards are accepted.

Returned Checks: Each returned check will incur a fee of $30.

Cancellations or Missed Appointments: We require a notice of 24 hours if you need to cancel or reschedule an appointment, or you will be billed directly at the rate of $25 for your missed appointments.

Paying in full at the time of service frees our office from the administrative costs that would be required in medical billing, we have adjusted our "usual and customary" fees. Your superbill/receipt form will show exam and treatment procedures that occurred during your visit. Depending on the visit and the nature of your treatment, certain procedure codes and/or exam codes may be modify payment and you will only be responsible for certain other fees: Your out-of-pocket fees will be as follows:

New Patient: $80
Follow-up: $65

Herbs, Supplements & Homeopathic: varies
B12 1CC / 2CC: $20 / $30

I have read and agree to the above Financial Policy.

_____ _____

Signature **Date**