Primary Care Holistic Center

8050 N Universwity Dr. #103 Tamarac, FL 33321 Telephone: (954) 752-8888

Initial Visit Information

Name ______________________ Date ____________

Address ______________ City ____________ State ________ Zip ________

Telephone ____________ Social Security # ____________ Driver Lic. # ____________

Age ________ Birth date ________ Sex ________ Status M S W D No. Children ________

Occupation ____________ Employer ____________ Years Employed ________

Employer's Address ____________ City ____________ State ________ Phone ____________

Spouse's Name ____________ Occupation ____________ Employer ____________

Person responsible for this account ____________ Referred by ____________

What is your major complaint? ______________________

____

Other complaints ______________________

How long have you had this condition? ____________ Have you had this or similar conditions in the past? ____________

What activities aggravate your condition? ______________________

Is this condition getting progressively worse? Yes ☐ No ☐ Constant ☐ Comes and goes ☐

Is this condition interfering with your: Work ☐ Sleep ☐ Daily routine ☐ Other ____________

How long has it been since you really felt good? ______________________

List Surgical operations: ______________________

____

Are you taking any medications? ________ What kind? ______________________

Any non-prescription drugs? ________ What kind? ______________________

OTHER DOCTORS SEEN FOR THIS CONDITION: MD ☐ DC ☐ DO ☐ DDS ☐

Doctor's Name ____________ Diagnosis ____________

X-rays ____________ Urinalysis ____________ Blood Tests ____________ Other ____________

Treatment: Medication ____________ Physiotherapy ____________

Results ____________ Length of time under care ____________

Were you off work? ________ if so, how long ________ Have you returned to your same job? ________ If not, why ________

INSURANCE INFORMATION:

Are you covered by Medicare? Yes ☐ No ☐ Medicare # ____________ State Insurance Aid? Yes ☐ No ☐

Do you have any group. union or personal health and accident insurance? Yes ☐ No ☐

Name of Insurance Company ____________ Claim # ____________ Group # ____________

Address ____________ Phone ____________ Agent ____________

Additional Insurance Company ____________ Claim # ____________ Group # ____________

Address ____________ Phone ____________ Agent ____________

Is your condition due to an accident? ☐ illness ☐ Other ____________

ACCIDENT INFORMATION:

Did your accident occur while at work? Yes ☐ No ☐ Were you involved in an automobile accident? Yes ☐ No ☐

Date ________ Time ________ Injury reported to employer ☐ Yes ☐ No Name of Supervisor ____________

Description of accident ______________________

____

Were you injured? ________ How? ______________________

Location ______________________

Were you unconscious? ________ Fractures ________ Cuts ________ Abrasions ________ Bruises ________

Patient taken to ____________ Hospital for ____________ Treatment.

confined to hospital for ________ Days ________ Hours. Name of hospital doctor ____________

Have you had any other personal injury or accident? ☐ Past year ☐ Past 5 years ☐ Over 5 years ☐ None

Describe ______________________

Do you have an attorney? ☐ Yes ☐ No Name & Address ______________________

____

____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me **will** be immediately due and payable.

Patient's Signature: ______________________ Date: ____________

PRIMARY CARE HOLISTIC CENTER

傅迪針灸中醫診療中心

TRADITIONAL CHINESE ACUPUNCTURE · HERBAL THERAPY · HOMEOPATHY

NOTICE TO PATIENTS

Thank you for choosing *Primary Care Holistic Center* for your health care needs. We are committed to your optimal health and strive to insure that your treatments are successful and your visits here positive. To help achieve this, it is important that you follow all instructions carefully.

When you come for your visits please remember the following:

1. Briefly tell the doctor your present symptoms (or bring a list).
2. Listen carefully to all instructions. Take notes if necessary.
3. Ask all questions while the doctor is seeing *you*; once he leaves your room, he must give his full attention to other patients who are waiting. Make yourself a list of questions before your visit, if you wish. Also, ask the doctor when you need to see him again to schedule your next appointment at the front desk while paying for treatment.
4. Please extend the same courtesies to other patients that you expect them to show you. Please be on time for your appointments. If something unexpected comes up, please call immediately to see if we can work you in later or re-schedule for another day. And remember to ask all your questions during ***your time*** with the doctor.

The following explains our office policies:

PAYMENTS Payments are due at the time of service. We accept cash, checks, MasterCard, Visa, Discover, and American Express.

INSURANCE We do not accept assignment, payments are due at time of service. We will file insurance for your reimbursement only if you have verified that acupuncture is covered. Please present your insurance card for us to photocopy.

MISSED APPOINTMENTS Unless cancelled 24 hours in advance, our policy is to charge the usual fee for an office visit missed. Your treatments will be more effective if you follow your treatment schedule and the doctor's instructions. Problems do arise and we will work with you as much as possible. However, we must have the courtesy of a call from you well in advance if you need to miss or re-schedule an appointment.

I have read and agree to the policies stated above.

__________________________ ________________

Patient's signature Date

PRIMARY CARE HOLISTIC CENTER

傳迪針灸中醫診療中心

TRADITIONAL CHINESE ACUPUNCTURE · HERBAL THERAPY · HOMEOPATHY

CONSENT FOR TREATMENT

I, ______________________, do consent for treatment in Primary Care Holistic Center. I understand that acupuncture, moxibustion, cupping, and NAET treatments may occasionally cause minor, temporary discomforts. I also understand that there are no guarantees regarding the above treatments or any remedies and herbal medicines prescribed.

I further understand that it is my responsibility to immediately report any reactions or discomforts related to the treatment to the health care attendant (if any should occur) and follow the instructions given.

I also state that I speak, read and write English, or that the contents of this form have been explained to me in my native tongue.

I have read and understand the above paragraphs and request that these procedures be used for my treatment as deemed necessary by my health care provider.

_____________________________________ ________
Patient's / Legal guardian's signature Date

_____________________________________ ________
Witness's Signature Date

8050 N. UNIVERSITY DR. STE 103 · TAMARAC, FL 33321 · USA

Tel 954.752.8888 · Fax 954.721.8843 · E-mail: drfudi@gmail.com

PRIMARY CARE HOLISTIC CENTER

傅迪鍼灸中醫診療中心

TRADITIONAL CHINESE ACUPUNCTURE HERBAL MEDICINE HOMEOPATHY

CANCELLATION POLICY

It is our desire to provide each patient with the highest quality service possible in the most expeditious manner. Therefore, we reserve a time slot for each patient with his/her physician to ensure minimal waiting time and maximum continuity of care.

In order to provide excellent service to all, we require that you call **24 hours in advance to change or cancel an appointment**. We must be able to accommodate emergency cases and patients who are waiting for a time slot. In the event that a patient demonstrates a pattern of disregard for this policy, a charge of $25.00 will be assessed to the account. Failure to pay a no show fee will be treated according to our policy on unpaid balances.

Primary Care Holistic Center reserves the right to discharge a patient who does not show up for (3) appointments without valid reason. However, we will not withhold medical care or direction for a medical emergency.

We appreciate your cooperation in this matter. Your courteous compliance with this policy allows us to treat all patients with respect and efficiency and accommodate emergency medical situations.

I have read and acknowledged this cancellation policy.

Signature: ___________________________________

Date: _______________________________________

Witness: _____________________________________

8050 N. UNIVERSITY DR STE 103 TAMARAC FL 33321 USA

Tel 954.752.8888 **Fax** 954.721.8843 **E-mail** drfudi@yahoo.com

PRIMARY CARE HOLISTIC CENTER

傅迪鍼灸中醫診療中心

TRADITIONAL CHINESE ACUPUNCTURE HERBAL MEDICINE HOMEOPATHY

INSURANCE VERIFICATION

Patient Name ______________________________

Acupuncture is not covered by all insurance policies. It is not a chiropractic or physical therapy benefit. You may have Blue Cross, Aetna, United, Cigna or one of the other large insurance carriers but that does not guarantee coverage. Please call your insurance company and provide us with the following information.

WE CANNOT VERIFY INSURANCE COVERAGE IN-HOUSE.

You must complete the form before we could initiate any insurance billing. Please ask specifically if you have acupuncture benefits!!

Date of call: ____
Number you called ______________________________________
Name or Extension of the agent you talked to _____________________
Do you have acupuncture benefits? ___________________________
How many visits do you have per year? ________________________
What is your deductible amount? $___________________________
How much deductible have you met this year? $__________________

You can bring the form into our office or fax it @ 954.721.8843

ATTENTION ALL INSURANCE PATIENTS

We require all insurance patients to pay a modest fee at the time of service. This will allow us to keep our prices affordable for all patients.

At each visit, you will be responsible for the consult fee only. The receipt will reflect that you paid this fee upfront. There are several procedures that may occur during each visit, and we well bill your insurance company for all the procedures performed, even though you are not paying for these up front.

Insurance companies can take up to 45 days to pay a claim. When we receive payment from your insurance company, we will refund up to the amount what you paid up front.

No insurance companies currently cover nutritional supplements, so we cannot refund any money for herbal prescriptions.

I have read and understand the information contained above.

Name ____________________________

Date _____________________________

8050 N. UNIVERSITY DR STE 103 TAMARAC FL 33321 USA

Tel 954.752.8888 **Fax** 954.721.8843 **E-mail** drfudi@yahoo.com

PRIMARY CARE HOLISTIC CENTER

傅迪鍼灸中醫診療中心

TRADITIONAL CHINESE ACUPUNCTURE HERBAL MEDICINE HOMEOPATHY

DISCLAIMER

I understand that Primary Care Holistic Center offers alternative / complementary / integrative medicine, which is commonly practiced in conjunction with conventional Western medicine. I understand that acupuncture should only be a unique part of my health care maintenance. I acknowledge that the practitioners at Primary Care Holistic Center are by no means substitutes for my primary medical physicians. I acknowledge my responsibility to see my own physician for disease diagnosis and treatments, as well as for any emergency situations.

Signature: ___________________________________

Date: ____

Witness: _____________________________________

8050 N. UNIVERSITY DR STE 103 TAMARAC FL 33321 USA

Tel 954.752.8888 **Fax** 954.721.8843 **E-mail** drfudi@yahoo.com