# Vitality WELLNESS CENTER

Name:			
	First	Last	
Birthdate:		Age:	_ In case of emergency contact:
Mailing Address	• •		
_			Relationship:
City	State	Zip Code	Home: ()
Homos /	,		Cell #: ()
			Referred Bv:
Cell #: (	)		Employer/ School:
E-mail Address:			Occupation:
Health Status:	/FO NO	Data	DIOCOMEONT 4 O O A F O 7 O O 40 INTENSE
- · · · · · · · · · · · · · · · · · · ·			DISCOMFORT 1 2 3 4 5 6 7 8 9 10 INTENSE
	•	S O NO O CONSTANT	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
		r: o WORK o SLEEP o	DAILY ROUTINE
		ned in the past? o YES	
		Tied in the past: • Teo	
•			
Using the adjacent	body, please circl	e all the affected area	s:
• • •	` ,	URNING (B) ○ THROBI	
` '	` ,	HOOTING (Sh) O TINGI	
o CRAMPING (C)	o STIFFNESS (St)	○ SWELLING (Sw) ○ □	OULL (D)
Any range of motion	n limitations:		) {} {
		G O WALKING O BENDIN	
		Physician for this cond	\ // /
If so, where:			) \
	-	cieved for your condition	
<ul> <li>MEDICATIONS</li> <li>S</li> </ul>	$SURGERY  \circ PHYSIC$	AL THERAPY O NONE O	OTHER:

### 1.1

Health Histor	·y					
•	f you have any of the	following:				
O ABNORMAL BLEE	EDING   where:	•	o HAIF	R   unexpected hair loss,		
ADDICTION   type:				if hair is graying, when did it start:		
ALLERGIES   type: airborn, food, shellfish			o HEA	DACHES   sinus, tension, r	migraine, unsure	
o ANEMIA   type:				how often:		
o ARTHRITIS   whe	ere:		o HEA	RT PALPITATIONS   how oft	en:	
o BACK PAIN   whe	ere:		o HEP	ATITIS   type:		
o CANCER   type:			o BLO	OD PRESSURE   high, low		
o Cardiovascula	R DISEASE		o HIV	+   how long:		
o DIABETES   type:			○ JOINT PAIN   where:			
	igestion, bloating, gas, he		○ LOW LIBIDO   how long:			
	constipation, irritable bow	-	PROSTATE DISORDERS   how long:			
	, Cronhs disease, Celiacs	, colitis, other:	o RES	PIRATORY DISORDERS   as		
O DIZZINESS   whe			OTD	pnemonia, chronic coug	h, other:	
• EAR DISORDERS				's   type:		
• EYE DISORDERS	· · ·	hinalau		JS ISSUES  type: NISSUES   eczema, psoria	cic aono drynacc	
	JES   depression, anxiety	, bipolar	O SKII	other:	sis, acrie, dryriess,	
other:	ofton		∩ THVI	ROID   hypothyroidism, hyp	perthyriodism	
• EPILEPSY   how	orten. OS / FLU  how often:			NARY/ KIDNEY   kidney sto		
• FATIGUE / WEAK			o Oran	UTI, urinate frequently, i	•	
• GALLSTONES   re	•			blood in urine, urinary difficulty		
Do you practice a	any stress managemo	ent techniques: o \	YES O NO	Do you take recrea	tional drugs: ○ YES ○ NO	
How many hours of	do you sleep:	Do you have vivid	dreams: o YES	5 ○ NO Is it difficult t	o fall asleep: O YES O NO	
Do you wake in the	e night: o YES o NO	Why:	<del></del>	If so, do you fall back a	asleep easily: o YES o NO	
Exercise	Work activity		Habits			
o NONE	o SITTING		o SMOKING	Packs/Day:		
o MODERATE	o STANDING		o ALCOHOL			
o DAILY	o LIGHT LABOR		o CAFFEINE	·		
• HEAVY	• HEAVY LABOR		○ ↑ STRESS			
	ou eat for each of the	following: O Sno	•	Neason		
<ul><li>Breakfast:</li></ul>	od eat for each of the	○ Lunch:	acks.	<ul><li>Dinner:</li></ul>		
Any Dietary Rest	rictions:	O LUTICIT.		o Diffiler.		
Ally Dietary Nest	nodons.					
List any past inju	iries and surgeries:	Description			Date	
Diagonalist and	adioations and reserv	nn.	Λ	autritional augustana - :	and harbar	
riease list ally II	nedications and reaso	л.	Any i	nutritional supplement	.5 and nervs.	

Woman's Health History:	Date of last gynecological exam:		
Have you ever had an abnormal PAP:		∘ YES ∘ NO	
Is there a chance you are pregnant:		∘ YES ∘ NO	
Do you use oral contraceptives:		∘ YES ∘ NO	
At what age did your menstral cycle start:			
At what age did your menstral cycle stop:			
What is the date of your most recent period:			
How many days does your period last:			
How many days pass from the start of one period to the	ne start of the next:		
Does this time vary by more than two days per cycle:		<ul><li>YES ○ NO</li></ul>	
Do you consistently have spotting for 2 or 3 days before	re your menses:	∘ YES ∘ NO	
Do you have blood clots or tissue in your menses:	•	∘ YES ∘ NO	
In general, how would you describe the color of your m	nenses:		
○ FRESH RED ○ BRIGHT RED ○ DARK RED ○ PUF			
Do you experience any of the following before, during,	or after your menses:		
○ ABDOMINAL PAIN ○ CRAMPING ○ LOW BACK PA	INO GENERAL BODY ACHES O HEADACHE	S O DEPRESSION	
$\circ$ Breast tenderness $\circ$ Breast swelling $\circ$ V	NATER RETENTION O FATIGUE O IRRATAB	BLITY O ANXIETY	
Do you have unusual discharge or laction from your ni	pples:		
Have you ever had a diagnosis of endometriosis:		∘ YES ∘ NO	
Have you ever had a diagnosis of polycysitic ovarian sy	yndrome:	∘ YES ∘ NO	
Have you ever had a diagnosis of uterine fibroids (myo		∘ YES ∘ NO	
Have you ever had a diagnosis of pelvic inflammatory	disease:	∘ YES ∘ NO	
Number of pregnancies:			
Number of births:			
Number of miscarriages/abortions:			
Was conceptions difficult:		∘ YES ∘ NO	
Did any health issues arise during any pregnancy / lak	oor / delivery:	∘ YES ∘ NO	
If you are currently trying to conceive, answer the following	; questions:		
How long have you been trying:			
Have you seen a western fertility specialist:		○ YES ○ NO	
If so, who:			
Do you track your ovulation:		∘ YES ∘ NO	
by: O URINARY LH STICK O BASAL BODY TEMPERA	TURE O CERVICAL MUCUS		
If so, do you ovulate on a regular basis each month:		∘ YES ∘ NO	
Do you have any blood relatives who have had a stroke	e, neart attack, or any other blood	\/=e	
clotting related disorder before 50 years old:		∘ YES ∘ NO	
Do you have any blood relatives who have had a digan		\/=e	
(multiple sclerosis, lupus, reynauds, rheumatoid arthr	itis, etc):	∘ YES ∘ NO	
Do you have a male partner:		∘ YES ∘ NO	
If yes, what is his age:			
Has he has a semen anyalysis:		○ YES ○ NO	

# — Informed Consent for Acupuncture Treatment —

The nature of acupuncture treatment: Some patients feel a bit light headed after a treatment. If this happens, please tell us. Even if you do not feel dizzy after a treatment, it is a good idea to take a few minutes to breathe deeply and regroup before heading out the door.

Herbal prescriptions and patent medicines are intended ONLY for the person for whom they are prescribed. Do NOT give your herbs to anyone else, even if it appears they have a condition similar to yours. State and local sales taxes are included in the price charged for herbs and herbal products.

**Possible risks**: Acupuncture needles may occasionally cause a small bruise. This is typically not cause for concern; however do call if you experience lingering discomfort or discoloration at the site of needle insertion. Only pre-sterilized, single use, disposable needles are used in this office.

. . .

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

I have had an opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture. I understand that results are not guaranteed.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedure. 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.

Alana Ramey-Bernardi, L. Ac., CMT • 831 . 325 . 9691

Neil Bernardi-Wright, L. Ac., FABORM • 408 . 402 . 1849

1011 Center St., Santa Cruz CA 95060 • 15251 National Ave, Ste. 106, San Jose CA 95035

Name:	Date:
Signature:	

Alana Ramey-Bernardi, L.Ac. // Neil Bernardi- Wright L.Ac. FABORM // 1011 Center St. Santa Cruz CA 95060

———— HIPAA Compliance Authorization ————
———— Patient Consent Form ————

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we deem are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. Unless you provide us in writing that you refuse, you agree that this office can share needed information about your treatment plan with your referring family physician and/or physician that you are being referred to.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, attorneys, collection agencies, law enforcement officials, worker's compensation, etc.), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. You, as the patient, have the right to receive one free copy of your medical records from this and any office where you have sought or received treatment.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restriction, and to revoke consent in writing after you have reviewed our privacy notice.

I acknowledge that I have received a HIPAA Compliance Assurance Notification.

Name:	Date:
Signature:	

Alana Ramey-Bernardi, L.Ac. // Neil Bernardi- Wright L.Ac. FABORM // 1011 Center St. Santa Cruz CA 95060

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Compl	liance	Assurance	Notu	ication
		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		

To our valued patients: The misuse of PHI has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problems of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us to prevent any inappropriate use of PHI.

We also know that we are not perfect. Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problems so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients!

Signature: \_\_\_

## Cancellation Policy & No-Show Policy

Please inform us at least 24 hours prior to your appointment if you need to cancel or reschedule your appointment. This allows us to offer this appointment slot to other patients who may have an immediate need for care.

Please be aware that a \$30.00 cancellation fee will be assessed if you are a no-show or fail to cancel with in 24 hours of your appointment.

Our acupuncture appointments generally take 50 + minutes. If you arrive more than 15 minutes late, this will count as a missed appointment. Unfortunately, we cannot guarantee that "late comers" will receive full time for their treatment.

In the case of an unavoidable emergency, this fee may be waived. If you have any questions, don't hesitate to ask.

Please accept below to acknowledge your understanding of our cancellation policy.			
Name:	Date:		
0:			

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### **Insurance Verification Form**

Patient please fill in up	per portion:			
Name:		Date of birth:		
Address:				
			Zip:	
Phone: H:	W:		C:	
Name of insured:		Relationship	: self spouse child other	
ID/Policy #:		Group#:		
Insured persons addres	s:			
Insurance company nar	ne and phone #:			
Insurance address:				
allowable, and otherw charges for professional policy. This payment was aid professional fees required by my insurant lalso hereby a submitted by Neil Bern this form shall be considered.	ise payable to me under my of services rendered. This is a will not exceed my indebtedness for non-covered services and/oce policy.  uthorize the release of any mardi-Wright and Alana Ramey-Idered as valid as the original.	current insurance purification direct assignment of to Neil Wright, L.A. or fees over and a sedical records necessity.	ssional or medical expense benefits policy as payment toward the total of my rights and benefits under this c., and I agree to pay any balance of above the insurance payment or as essary for the processing of claims as rendered to me. A photocopy of Date:	
Patient Signature:		<del></del>	Date:	
1011 Center	Alana Ramey-Bernardi, L. Ac., Neil Bernardi-Wright, L. Ac., St, Santa Cruz CA 95060 // 1525	, FABORM • (408) 4	02- 1849	
Office Use: Billing Addr.	.:			
			Diagnoses:	
Deductible:	Co-pay:	Pay rate:	Visit limit:	
Ref. By:	w/c	PI MM Other	Injury Date:	
Notes:				