Fingers From Heaven

Dr. Connie Tjaden, D.Ac., LMT

464 Route 25A

Miller Place, New York 11764

631-680-9458

REGISTRATION FORM

Patient Name: _____ **Date:** _____

Age: _____ **Date of Birth**: _____ **Gender: M / F**

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email Address:** _____

SS #: _____

Emergency Contact: _____ **Phone:** _____

Dr. Connie Tjaden D.Ac., LMT, is an Out of Network Provider,
but may assist with insurance reimbursement.
All payments are due at the time of treatment.

Primary Insurance: _____**Policy #**_____

Insurance Policy holder (name): _____

Relationship to Patient: _____ **Date of Birth**: _____

Address (if different from above)_____

Contact or Claims Adjuster: _____

Assignment and Release of Information statement: I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the release of information related to my medical care as requested, by government agencies and/or insurance carriers. I hereby assign benefits, and understand that in the absence of accepted insurance coverage, I/Legal guardian am responsible for full payment of services rendered. **Litigation Disclaimer:** It is understood, and agreed, that I am requesting examination and treatment for medical purposes only, and not requesting any information in connection with pending or proposed litigation.

Authorized Signature/Guardian: _____**Date:** _____

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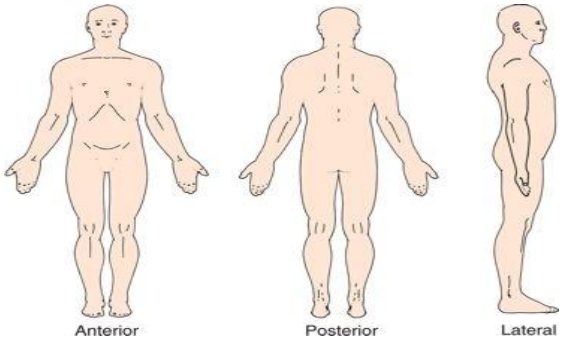
Chief Complaint: _____

Date of injury or symptom onset: _____

Please describe the injury or problem: _____



Where is your pain? Please mark the drawing

Please indicate your pain level
0 = No pain 10 = Extreme pain

1. Right now 0 1 2 3 4 5 6 7 8 9 10
2. At best 0 1 2 3 4 5 6 7 8 9 10
3. At worst 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better? _____

5. What makes it worse? _____

Circle the words which best describe your symptoms:

Dull/Achy	Shooting	Awareness	Sharp/Stabbing	Burning
Throbbing	Heaviness	Weakness	Tightening/Constricting	Numbness

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What diagnostic tests have you had for this condition? (X-ray, MRI, EMG, etc.)

Diagnostic test	Date	Results

Please list all treatments that you have tried for you condition including physical/occupational therapy, massage, acupuncture, chiropractic, injections, and medications (please list type of injection and/or medications).

_____

_____

Past Medical History

Please list any ongoing medical problems (High blood pressure, Diabetes, Thyroid disorder, Cancer, Bleeding disorder, Heart disorder, Asthma, Arthritis, Headaches)

_____

_____

Past Surgical History

_____

_____

Current Medications, Vitamins, or Nutritional Supplements

Medication	Dosage	Frequency

Are you allergic to any medication? Yes or No If yes, please list.

_____

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Family History

Does anyone in your family have any of the following problems?

Heart disease High blood pressure Cancer Nerve Disorders Stroke Diabetes Blood problems
Other_____

Symptom Review (circle symptoms you have experienced in the past week)

Chest Pain	Leg Swelling	Numbness	Excess Sweating	Difficulty Breathing	Digestive Symptoms	Tingling
Hair Loss	Visual Changes	Weakness	Bruising	Hearing Loss	Joint Stiffness	Joint Pain

Other/Explanation: _____

Please provide Physician information

Primary Care Physician	Name:	Phone:	Fax:
Referring Provider	Name:	Phone:	Fax:

What is your occupation? Are you retired or disabled? Yes or No

What type of physical activity do you do, and for how many hours per week?

Do you smoke, drink alcohol, or use illegal substances? If yes, how often?

Are you currently pregnant? Yes or No

The information I have provided is accurate and complete, to the best of my knowledge:

Signature: _____ Date: _____

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CONSENT FORM

I, _____ understand that as part of my health care, **Fingers From Heaven**, will create and maintain, health records describing my health history, symptoms, examinations, and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that this information serves as a:

• Mode of communication among the many health professionals who contribute to my care

• Source of information for applying my diagnosis information to my bill

• Basis for planning my care and treatment

• Means by which a third-party payer can verify that services reported were actually provided

• A tool for routine healthcare operations, such as assessing the quality, and reviewing the competence, of healthcare professionals

• Anonymous data may be used to track clinical progress to use for research purposes

I understand that I am entitled to a more complete description of this information, uses, and disclosures. I understand the organization reserves the right to change their notice and practices, prior to implementation, and will mail a copy of any revised notice, to the address above, that I've provided. I understand that I have the right to object to the use of health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used, or disclosed, to carry out treatment, payment, or healthcare operations, and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I also fully endorse responsibility for all fees related to my care. I understand that my insurance provider may or may not, reimburse me for these services, and I will remain wholly responsible for payment.

I fully understand, and accept, the terms of this consent.

Signature: _____ Date: _____

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CONTRACT FOR PAYMENT TO PROVIDER FOR INSURANCE CLIENTS

I, _____ ("Assignor") hereby agree to pay **Dr. Connie Tjaden**, **D.Ac., LMT** ("Assignee") all **(Print Patient Name)**

monies due to her that are due to her for services performed for Acupuncture and Massage Therapy services. Once you receive the insurance check, you are required endorse the back of the check, and give it to her within 10 days of receiving the check.

If you do not endorse the check paid out for above mentioned services, you are required to pay out of your own pocket the exact same amount to Connie Tjaden, L.Ac., LMT.

_____ _____

(Print name of Patient) (Signature of Patient)

_____ _____

(Address of Patient) (Date of Signature)

_____ _____

(Signature of Provider)

_____ _____

(Date of Signature)

Provider**: Fingers From Heaven**
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AUTHORIZATION TO PAY THE ACUPUNCTURIST/MASSAGE THERAPIST

I hereby direct, and instruct the _____ Insurance Company, to pay by check, made out, and mailed directly to, **Fingers From Heaven, Inc.**

If my current policy prohibits direct payment to any professional, then I hereby authorize you to make the check payable to me, and mail to the providers address as listed below:

_____ (Patient's Name)
Fingers From Heaven, Inc.
464 Route 25A
Miller Place, New York 11764

This is a Direct Assignment of my rights, and benefits under this policy.

I agree to pay for services rendered to the above-mentioned patient, as the charge is incurred. I understand that health and no-fault insurance policies, are arrangements between an insurance carrier and myself, and that I am personally responsible for payment, of any, and all services covered, or not covered. If the provider is a contracted provider for my managed care plan, I understand that I am responsible for all co-payments, and non-covered services. I also understand, and agree to pay all co-payments and fees, for non-covered services, prior to seeing the professional. I understand that if I terminate my care and treatment, any fees for professional services rendered to me, will be immediately due, and payable.

I hereby authorize, and direct payment of any medical/professional services expense benefits allowable to professional, as payment toward the total charges for services rendered. This payment will not exceed my indebtedness to the assignee. **This is a direct assignment of my rights under this policy. I agree that a photocopy of this agreement shall serve as the original.**

Authorization to Release Information

I hereby authorize **Fingers From Heaven, Inc.,** and their staff, to release or request any information deemed appropriate, concerning my physical condition, to and from the Insurance Company, claims adjuster, nurse case manager, claims reviewer, etc., health care provider or attorney. I also authorize the _____ Insurance Company, to process the claim for reimbursement, for charges incurred by me, as a result of professional services rendered. I hereby release him/her of any consequences thereof. **I agree that a photocopy of this agreement shall be considered the original.**

_____ _____
(Signature of Policy Holder or Claimant) **Date**

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Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

Fingers From Heaven, appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage, and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. This Statement of Patient Responsibility will assist you in understanding that financial responsibility. By your acknowledgement of this statement you agree:

- **Out-Of-Network:** You are required to provide your insurance card or other insurance verification at the time of your visit. You are required to follow all registration procedures, which may include updating any personal information.

  You are responsible for knowing your insurance policy, if you are unfamiliar with your insurance coverage plan, we recommend you contact your carrier or plan provider directly.

  You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

  We will verify your insurance benefits and submit claims to your insurance company as a courtesy to you. All out-of-network correspondences will be mailed to you, the patient, within 30-45 days after your insurance company has responded to a submitted claim. It is your responsibility to submit the Explanation of Benefits along with the check to your provider.

I have read the above policy regarding my financial responsibility to **Fingers From Heaven**, for providing Acupuncture services to me, or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to **Fingers From Heaven**, the full and entire amount of bill incurred by me, or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____
(If guarantor is not the patient)

Consent for Treatment, and Authorization to Release Information

I hereby authorize **Fingers From Heaven**, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment, and treatment procedures.

I further authorize **Fingers From Heaven**, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature: _____ Date: _____