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Dr. Lindsay Hood, A.P., D.O.M.

Welcome New Patients,

Thank you for choosing HoodMed, LLC for your health care needs. We are excited that you have chosen us to assist you in your journey towards healing!

Our practice combines aspects of Eastern Medicine, Acupuncture, Functional Medicine, Supplementation, and Herbal Medicine. Our Mission is to integrate these services to help you achieve your health goals. Our staff is committed to providing excellent holistic care and we are dedicated to helping you become healthy and well! Our practice is unique because our clinicians will take the time to listen to your concerns and will provide you with the education and tools you need to continue your health journey outside of the clinic.

We would like to take a moment to introduce a few of our office policies:

The following is information needed for your first visit. **Please complete all forms in their entirety** and bring them to your appointment. **PLEASE ARRIVE AT LEAST 30 MINUTES BEFORE** your first scheduled appointment time so that we may process your paperwork. It is critical that our patients arrive early on their first visit to allow our clinic to maintain a safe and comfortable work-flow. It is our goal to provide our patients with access to the practitioner at all times, and scheduling your appointments will assist us in satisfying that goal, therefore, we are not accepting walk-ins at this time.

Please remember to bring the following to your appointment:
1. Insurance Card(s)
2. Driver's License or photo ID
3. Any Labs and/or test results or records from your doctor, detailing any medical conditions with which you may have been diagnosed.
4. A list of all your medication and dosages you are currently taking (including over the counter medications).
5. Any copay, deductible, and/or coinsurance you are responsible for will be collected upon check-in. Please contact our office or your insurance company prior to appointment if you are not sure what your copay, deductible, or coinsurance might be.
6. Cash patients should expect to provide payment at the time that services are rendered.

****We accept Cash and all major credit cards. NO CHECKS. ****
Thank you again for opportunity and confidence in allowing us to participate in your care!

_________________________________ _________________________
Patient Signature **Date**

Acupuncture Intake Form

Please complete this questionnaire carefully. The information you provide will assist me in creating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Patient Information (Please Print)

Name:______________________________________ Date of First Visit:____________________________

Date of Birth:______________________M / F Occupation:_______________________________________

Address:____Postal Code: ______________

Phone: (H) ______________________ (W) _____________________ (Cell) _________________________

Email Address___________________________________Preferred method of contact: Home Cell E-Mail

Family Doctor:____Phone________________________

Emergency Contact Name:____________________________________Phone:________________________

How did you hear of us?____

Will you be using insurance today? ____

Verify your insurance using this link: Insurance Verification Form

Have you ever had Acupuncture before? YES NO

What is your primary reason(s) for treatment today?

____

____

____

Have you visited a medical doctor for this condition? YES NO

If yes, did you receive a diagnosis? NO YES: ____

Are you currently receiving any other treatments for this condition? YES NO

If yes, please describe treatments and how effective they have been: _________________________________

____

____

Please list any current medications (prescription and over the counter), vitamins, supplements, herbs or homeopathic remedies that you are taking, including dosage if you know it

____

____

____

____

For females: Are you pregnant? NO Possibly YES How far along? ___________

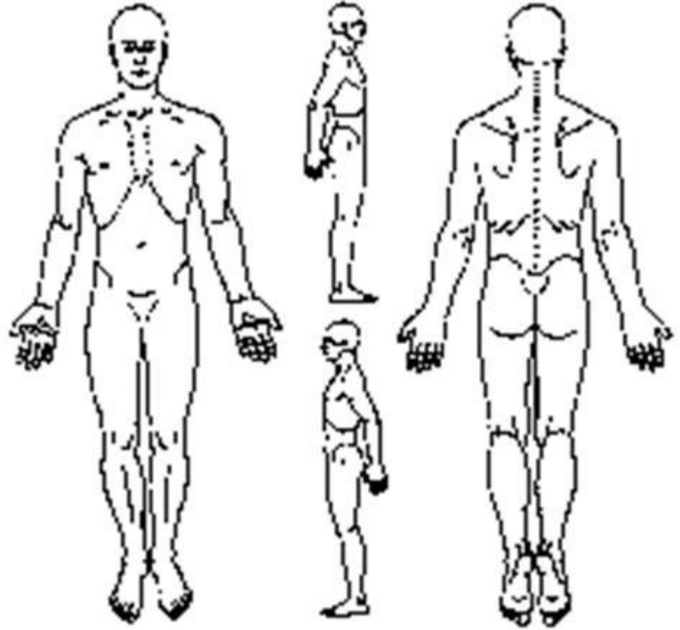
Do you have a contagious disease at this time? NO YES: ____________________________________

If you are seeking treatment for a painful condition, please describe the pain and shade in areas of pain on the diagram below

Pain Condition #1 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain

O Constant
O Comes and goes
O Fixed
O Moves
O One side
O Both sides
O Sharp
O Dull
O Burning
O Aching
O Spastic
O Numb



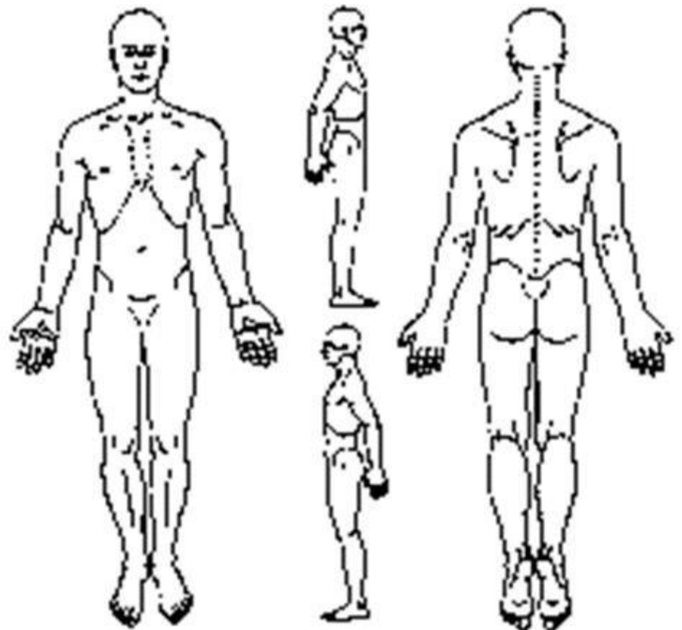
Does the pain get better, or worse with?

O Heat *better* *worse* O
Cold *better* *worse* O
Motion *better* *worse* O
Rest *better* *worse* O
Pressure *better* *worse* O
Better in *AM* or *PM*?

Pain Condition #2 *Degree of pain* (please circle 1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Nature of the Pain

O Constant
O Comes and goes
O Fixed
O Moves
O One side
O Both sides
O Sharp
O Dull
O Burning
O Aching
O Spastic
O Numb



Does the pain get better, or worse with?

O Heat *better* *worse* O
Cold *better* *worse* O
Motion *better* *worse* O
Rest *better* *worse* O
Pressure *better* *worse* O
Better in *AM* or *PM*

Do you have any of the following?

O Pacemaker
O Surgical replacements
O Implants
O Hemophilia
O Sensitive skin
O Fear of needles
O Latex allergy
O Nut allergy

O Other allergy ____

Is There Family History of:

O Alcoholism
O Allergies
O Asthma
O Bleeding disorders
O Cancer
O Depression
O Diabetes
O Heart disease
O High blood pressure
O Kidney disease
O Mental illness
O Seizures
O Stroke

O Other____

How much do you consume per day of:

Water ________ Coffee ________ Tea ________ Soda ________ Alcohol_______Cigarettes _______

Generally, do you prefer □ warm drinks □ cold drinks □ room temperature drinks?
Do you find that you are □ always thirsty □ rarely thirsty or □ thirsty for sips later in the day?

What are your typical eating habits?

O Skip Meal(s)____________
O Eat in a Rush
O Eat When Not Hungry
O Eat too Fast
O Cannot eat when Worried/Stressed
O Excess Hunger
O No Desire to Eat
O Eat late at night

O Craving specific food(s)____
O Other: ____

What are your typical sleeping habits?

O Hours slept/night _______
O Fall asleep quickly
O Trouble falling asleep
O Difficulty waking up
O Trouble staying asleep
O Deep sleeper
O Light sleeper
O Frequent dreaming
O Disturbing dreams
O Wake at same time every night _________

O Other ____

How would you describe your energy levels?

O High
O Low
O Normal
O Lethargic
O Hyperactive
O Changes from day to day

O Other ____

Do you have aversion to any of the following?

O Cold
O Wind
O Dampness
O Heat
O Loud Noises
O Crowds

O Other ____

What is your Average Body Temperature?

- O Hot
- O Cold
- O Cold Hands & Feet
- O Hotter @ Night
- O Colder @ night
- O 5 Center Heat
- O Hot Joints
- O Other ______________________________

General Information

- O Anorexia/Bulimia
- O Chronic Fatigue
- O Chicken Pox
- O Chronic Pain
- O Fibromyalgia
- O Hepatitis _______
- O HIV
- O Herpes/Cold Sores
- O Lupus
- O Lyme disease
- O Meningitis
- O Scarlet Fever
- O Mononucleosis
- O Multiple Sclerosis
- O Rheumatoid Disease
- O Rheumatic Fever
- O Mumps
- O Tuberculosis
- O Thyroid Disease
  - o Overactive
  - o underactive
- O Measles
- O Pneumonia
- O Tonsillitis
- O Cancer: ______________________________
- O Other: ______________________________

Head, Eyes, Ears, Nose and Throat

- O Bitter taste
- O Blurred vision
- O Cataracts
- O Grinding of teeth
- O Goiter
- O Gum problems
- O Ringing in ears
  - o High pitch
  - o Low pitch

- O Concussions
- O Dry mouth / nose
- O Ear aches
- O Excess phlegm
- O Eye pain or strain
- O Facial pain
- O Glasses or contacts
- O Glaucoma
- O Headaches
- O Hearing aids
- O Itchy eyes
- O Migraines
- O Nose bleeds
- O Poor hearing
- O Red or dry eyes
- O Sinus issues
- O Spots in eyes
- O Swollen glands
- O Teeth issues
- O TMJ Syndrome
- O Trigeminal neuralgia
- O Watery eyes
- O Other: ______________________________

Respiratory:

- O Asthma/Wheezing
- O Frequent colds
- O Allergies
- O Bronchitis
- O Cough
- O Cough + Phlegm
- O Emphysema
- O Heavy Chest
- O Pneumonia
- O COPD
- O Cough + blood
- O Difficult breathing
- O Tight Chest
- O Short of Breath

- O Other: ______________________________

Cardiovascular:

- O Anemia
- O Arteriosclerosis
- O Easily bruised
- O Poor circulation
- O Blood clots
- O Fainting
- O High cholesterol
- O Low blood pressure
- O Palpitations
- O Chest pain
- O High blood pressure
- O Irregular heart beat
- O Pace maker
- O Phlebitis
- O Stroke

- O Heart Disease: ______________________________
- O Other: ______________________________

Gastrointestinal

- O # Bowel Movements/day____
- O Normal Stool
- O Loose stool
- O Constipation
- O Pain after BM
- O Heartburn/acid reflux
- O Abdominal pain
- O Bad breath
- O Rectal pain/itching
- O Hemorrhoids

O Diarrhea
O Undigested food in stool
O Mucous in stool
O Blood in stool
O Strong odour
O Pain before BM
O Appendicitis
O Bloating
O Celiac Disease
O Gas
O Hiccups
O Nausea/vomiting
O Hernia
O Liver Disorder
O Ulcer
- H. Pylori Negative
- H. Pylori Positive
- Not Tested

O Other: ____

Genito-Urinary

O Bed wetting
O Bladder infections
O Bloody urine
O Frequent urination
O Painful urination
O Incomplete urination
O Incontinence
O Urgent urination
O Wake to urinate
O Pale urine
O Dark urine
O Cloudy urine
O Kidney stones
O Kidney Disease
O Libido issues
O Yeast infection
O Impotence
O Prostate Disorder
O Premature ejaculation
O Nocturnal emissions
O Other: ____

Gynecological

O Menopause
O Oral Birth control pills
O Intra-Uterine Device IUD
O Breast lumps
O Genital burning
O Genital itching
O Genital discharge
O Genital swelling
O Hysterectomy
O Endometriosis
O Fibroids
O Cysts
O PMS – headaches
O PMS – back aches
O PMS – mood swings
O # Pregnancies _________
O # Miscarriages__________

Menstruation Information:

O Heavy periods
O Light periods
O Irregular periods
O Pain Before
O Pain During

Describe the menstrual blood:

O Pain After
O Dark Red
O Bright Red
O Pale Red
O Brownish
O Thin/Watery
O Very thick
O Clots?
- Size _________
- Color _________

Days between periods___________# days of period___________
Other Information: ____

Skin and Hair

O Acne
O Burning skin
O Dandruff
O Dermatitis
O Discolorations
O Eczema
O Fungal infection
O Hair loss
O Hot flashes
O Heavy sweating
O Not able to sweat
O Hives
O Itchy/dry skin
O Psoriasis
O Rashes
O Shingles
O Warts

O Other: ____

Neuro-Psychological

O ADD/ADHD
O Addiction
O Anxiety
O Depression
O Easily stressed
O Epilepsy
O Irritability
O Mental illness
O numbness
O “Foggy” feeling
O Poor coordination
O Parkinson’s Disease
O Poor memory
O Seizure
O Vertigo/Dizziness

O Other: ____

Musculoskeletal:

O Osteoarthritis
O Rheumatoid arthritis
O Atrophy
O Body heaviness
O Joint pain
O Limited motion
O Limited use
O Back pain
O Muscle pain
O Muscle cramps
O Neck pain
O Rib pain
O Scoliosis
O Weight gain
O Weight loss

O Broken Bones: ____

O Other: ____

Financial Policy and Authorization to Bill Insurance

Dear Patient,
There are two billing options available for you. Please select the one that applies to your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Financial Policy and Authorization to Bill Insurance Form.

_____ **Private Pay/Uninsured Patients**
Patients not covered by any insurance plans or covered by insurance policies that we are unable to bill directly should expect to pay for services billed at our standard rates. All payments will be collected at the time that services are rendered. If you are unable to pay the standard amount, please discuss your needs with your practitioner and other payment options may be available to you.
New Patients should be prepared to pay up to ***$165 for the initial consultation.***
Established Patients should be prepared to pay ***$85 for each follow-up visit.***

_____ **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 in for today's visit, and every visit hereafter. HOODMED will submit my claim for me to my insurance company. Although HOODMED 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 not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid. I further understand that any unpaid balance over 90 days, can and will be sent to collections for recovery unless prior arrangements have been made.

NO SHOW POLICY

Patients who miss their appointments without calling and canceling or rescheduling at least 24 hours in advance of the appointment will be assessed a ***$35 no show fee***. Patients that show up for their appointment more than ***15 minutes*** late may need to reschedule their appointment to a later time/date as the original appointment time may no longer be available***. In the unlikely event that you not show to 2 consecutive appointments, you will give us no choice but to terminate our professional relationship.***

REQUEST FOR RECORDS

If you request copies or transfer of medical records you will be charged $1.00 per page up to 25 pages, and then an additional $.25 per page thereafter. This is in accordance with Florida statutes.

FORM COMPLETION

Our office charges a flat fee of $10 for the completion of any forms which require the physician to review your chart and fill out. ***Prepayment is required*** before the form will be completed.
I authorize my insurance benefits to be paid directly to HoodMed. I also authorize the provider 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.

Patient Signature: ____ Date: _________________

Parent or Guardian Signature: ___________________________________ Date: _________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose Protected Health Information (PHI). The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare options.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may provide treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **Yes No**

May we leave a message on your answering machine at home or on your cell phone? **Yes No**

May we discuss your medical condition with any member of your family? **Yes No**

If YES, please name the members allowed:
Name: ____
Relationship to Patient: _________________________
Name: ____
Relationship to Patient: _________________________

Signature of Patient or Legal Guardian: ____
Patient Name (Print): ____
Date: ______________________ Witness: ____