

THE CENTER FOR INTEGRATIVE MEDICINE

University of Maryland School of Medicine



Welcome New Patient

We at the Center for Integrative Medicine Clinic are looking forward to partnering with you to meet your health needs. Our physicians are board certified and trained in Integrative Medicine. We offer primary care services, as well as consultations and other therapies. We are excited to assist you in creating a plan for optimal health and to address your unique needs.

Your First Consultation

This appointment will last approximately 60 to 90 minutes. You will be asked to provide information regarding your past medical history and your current symptoms. **Please remember to arrive 10-15 minutes early for your appointment, bring any supplements or prescriptions you are currently taking and your insurance card.** After this appointment, your physician will make recommendations concerning further treatments and/or other options.



Attached you will find all of the paperwork necessary for your first visit. This paperwork should be filled out completely and brought with you to the clinic. Please see the attached directions to our clinic. Parking is free at Kernan Hospital. If you have any questions concerning the paperwork or our clinic call us at 410-448-6361.

THE CLINIC AT THE CENTER FOR INTEGRATIVE MEDICINE

2200 Kernan Drive | Clinical Services, 2nd Floor North | Baltimore, MD 21207
clinic@compmed.umm.edu 410.448.6361 www.compmed.umm.edu

Primary Care ✧ Physician Consultations ✧ Acupuncture ✧ Psychotherapy/Counseling ✧ Massage
Homeopathy ✧ Osteopathic Manipulation ✧ Craniosacral Therapy ✧ Nutritional Counseling ✧ Shiatsu
✧ Reflexology ✧ Yoga ✧ Qi Gong ✧ Tai Chi

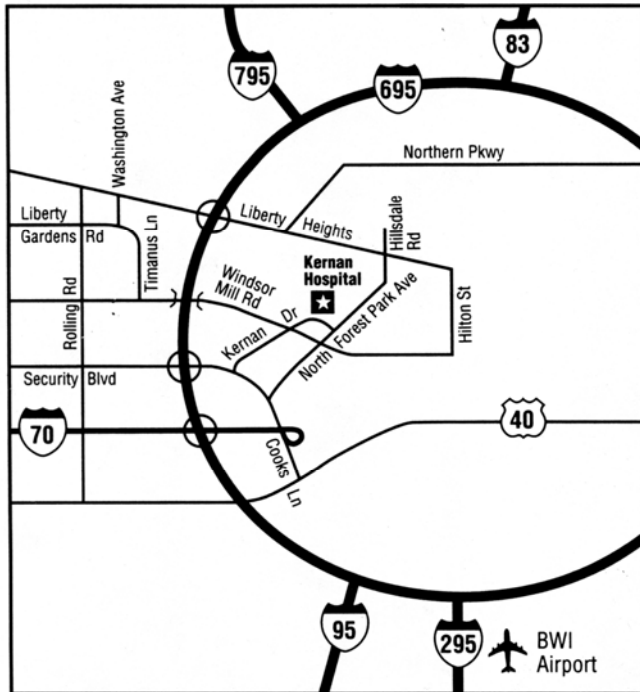




**UNIVERSITY OF MARYLAND
CENTER FOR INTEGRATIVE MEDICINE, LLC**

**Kernan Hospital
2200 Kernan Drive
2nd Floor North
Baltimore, MD 21207**

DIRECTIONS



By Car:

Parking is plentiful and free on Kernan's campus. Handicapped parking is available near the main entrance. There also is a drop-off/pick-up area.

From the Beltway (695): Take exit 17 East onto Security Boulevard (Woodlawn). Approximately two miles east of the Beltway, turn left at the light onto Kernan Drive and follow it across Windsor Mill Road into the hospital driveway.

From I-70 (or Beltway exit 16): Follow "Local Traffic" to Security Boulevard. At the second light, turn right onto Kernan Drive and follow it across Windsor Mill Road into the hospital driveway.

From Rt. 40 West (Baltimore City): Make a right at Coombs Lane and follow onto Security Boulevard. Turn right onto Kernan Drive and follow it across Windsor Mill Road into the hospital driveway.

By Bus:

Westbound (from downtown Baltimore) The #15 bus ("Social Security/Security Square Mall") goes past the main entrance of Kernan Hospital on Windsor Mill Road then turns left onto Kernan Drive. Get off at the first stop on Kernan Drive and walk back to the hospital

Eastbound (toward downtown Baltimore) The #15 bus ("Downtown") goes up Kernan Drive. As you approach your stop, you will see the main entrance to Kernan Hospital straight ahead. Get off at the last stop on Kernan Drive before the bus turns right onto Windsor Mill Road.

By Cab:

Arrow Cab: 410-358-9696

Yellow Cab: 410-685-1212

County Cab: 410-788-8000

By Air:

Kernan Hospital is approximately a 30-minute drive from Baltimore Washington International Airport, approximately 60 minutes from Washington National Airport.

For more information, call the Mass Transit Administration at (410) 539-5000.



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PATIENT HEALTH HISTORY QUESTIONNAIRE

(To be kept as part of your confidential Medical Records)

Patient's Name: _____ **Medical Record Number:** _____

Today's Date: _____ Patient's Date of Birth: _____

Person completing this form: _____

Do you have any allergies or have you had any reactions to any medications? YES NO

Please list medicines and reactions:

Do you have a living will? YES NO (if no please ask medical assistant for one)

Please list all medicine/vitamins/herbs you are currently taking:

| Name: | Strength (mg): | Taken how: | First started when: |
|-------|----------------|------------|---------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PAST MEDICAL AND FAMILY HISTORY REVIEW:

Have you had or do you currently have:

If a family member has suffered from this as well, please tell us how they are related to you:

- | | | | |
|--|-----|----|-------|
| Diabetes ("sugar") | YES | NO | _____ |
| Glaucoma | YES | NO | _____ |
| Bleeding disorder or blood disease | YES | NO | _____ |
| Asthma or hay fever | YES | NO | _____ |
| High blood pressure | YES | NO | _____ |
| Stroke | YES | NO | _____ |
| Heart attacks or chest pain | YES | NO | _____ |
| Seizures, convulsions, blackouts | YES | NO | _____ |
| Cancer: type _____ | YES | NO | _____ |
| Ulcers, stomach or intestinal bleeding | YES | NO | _____ |
| Heart murmur/rheumatic fever | YES | NO | _____ |

Angry, or abusive times that result in violence with a household member? YES NO

Told that you snore loudly or seem to stop breathing in your sleep? YES NO

Please turn over

Surgeries: _____

Hospitalizations (other than childbirth): _____

Immunization Status:

Have you had a pneumonia shot? YES NO DON'T KNOW

When was your last tetanus vaccine/booster? _____

Other vaccines? If so, what vaccine and when? _____

| | |
|---|--|
| FEMALES ONLY <i>Menstruation:</i> Age of Onset: _____ No. of pregnancies: _____ No. of live births: _____ No. of miscarriages: _____ If having sex: <i>Birth Control Method:</i> _____ Brand of Birth Control Pills: _____ | MALES ONLY Do you ever have trouble with erections? YES NO Do you find it necessary to empty your bladder frequently, or notice difficulty in starting to pass your urine? YES NO How many times do you awaken at night to empty your bladder, if at all? _____ |
|---|--|

SOCIAL LIFESTYLE

Tobacco Use? YES NO If yes, # of packs per day _____ for _____ years.

Are you an ex-smoker? YES NO If yes, how many packs per day did you smoke? _____

Alcohol User? YES NO If yes, type and amount per day _____

Do you have a regular exercise program? YES NO

Do you use "street drugs"? YES NO If yes, type and amount per day _____

| |
|---|
| PREVENTION AND SURVEILLANCE: When was the last time you: Had a bowel movement test using a cardboard slide (hemocult) for hidden blood? _____ When was the last time you had an eye exam? _____ Had a dental exam? _____ If female: Had a mammogram? _____ Had a pap test? _____ Discussed breast self-exam with a doctor? _____ Had a breast exam by a doctor? _____ If male: had a prostate check? _____ Do you wear seat belts? YES NO |
|---|

Do you see any other doctors, physical therapists, etc.? _____ YES NO

If so, please list their name, phone number, and when you last had an appointment to see them.

| Name | Phone Number | Last Appointment Date |
|------|--------------|-----------------------|
| | | |
| | | |

| |
|--|
| <i>Staff / clinician use only:</i> Action taken: Discussed at this visit _____ YES NO Recommended patient make follow up visit to discuss _____ Reviewed by: _____ D.O./M.D. (Please circle) |
|--|



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DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____

How did you hear about our office? (Please Circle) Internet Newspaper Doctor Referral
 Friend: (name) _____ Other: _____

PATIENT INFORMATION

| | | | | | |
|--|----------------------|----------------------|--|----------|----------------|
| Last | First | Middle Initial | Email Address | | |
| SSN | DOB | Gender | Would you like to be on our mailing list? Yes / No (circle) | | |
| Patient Address | | City | State | Zip Code | |
| Patient Home Phone # | Patient Work Phone # | Patient Cell Phone # | Religion | Race | Marital Status |
| Preferred Method of Contact: Home # / Cell # / Work # / Email / Other: | | | | | |

EMERGENCY CONTACT INFORMATION

| | | |
|------------------------|---------------------------|---------------------------|
| Emergency Contact Name | Emergency Contact Address | Emergency Contact Phone # |
|------------------------|---------------------------|---------------------------|

REFERRING PHYSICIAN INFORMATION

| | | |
|-------------------------------|----------------------------|--------------------------------|
| Referring Physician Name | Address | Phone # |
| Referring Physician Specialty | Referring Physician UPIN # | Referring Physician Taxonomy # |

PRIMARY INSURANCE INFORMATION

| | | | |
|--------------------------|-----------------------------|--|----------------|
| Insurance Company Name | Insurance Company Phone # | Address to Submit Claims: | |
| Insurance Policy # | Insurance Group # | Insurance Effective Date From To | |
| Subscriber Name | Subscriber Gender | Subscriber DOB | Subscriber SSN |
| Subscriber Address | | Subscriber Phone # | |
| Subscriber Employer Name | Subscriber Employer Address | Subscriber Employer Phone # | |

Please Turn Over

SECONDARY INSURANCE INFORMATION

| | | | |
|--------------------------|-----------------------------|--|----------------|
| Insurance Company Name | Insurance Company Phone # | Address to Submit Claims: | |
| Insurance Policy # | Insurance Group # | Insurance Effective Date From To | |
| Subscriber Name | Subscriber Gender | Subscriber DOB | Subscriber SSN |
| Subscriber Address | | Subscriber Phone # | |
| Subscriber Employer Name | Subscriber Employer Address | Subscriber Employer Phone # | |

Please read and sign.



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FINANCIAL POLICY

INSURANCE PARTICIPATION

Our clinic participates with most major insurance companies including the following:

| | |
|--------------------------------------|--|
| AARP | KAISER PERMANENTE |
| AETNA | MAMSI LIFE & HEALTH |
| AFL-CIO | MARYLAND HEALTH INS. PLAN (MHIP) |
| ALLIANCE | MDIPA |
| BLUE CHOICE | MEDICARE |
| BLUE CROSS/BLUE SHIELD QUALITY CARE | NATIONAL CAPITAL PPO |
| CAREFIRST BLUE CROSS/BLUE SHIELD | NATIONAL PROVIDER NETWORK (NPN) |
| CAREFIRST BLUE CROSS/BLUE SHIELD POS | NATIONAL PREFERRED PROVIDER NETWORK (NPPN) |
| CIGNA | OPTIMUM CHOICE |
| COVENTRY HEALTH CARE OF DELAWARE | PREFERRED HEALTH NETWORK (PHN) |
| DELMARVA HEALTH PLAN | TRICARE PRIME |
| FIDELITY BENEFITS | UNITED HEALTH CARE SELECT |
| GEHA | UNITED HEALTH CARE OF THE MID-ATLANTIC |
| GREAT WEST ONE PLAN | UNITED HEALTH CARE CHOICE |
| GREAT WEST POS | UNITED HEALTH CARE POS |
| HUMANA-CHOICE CARE | USA MANAGED CARE NETWORK |
| INNOVATIVE HEALTH SERVICES | WESTERN MARYLAND HEALTH SYSTEM |

The responsibility of providing complete and accurate insurance information to our office staff belongs to you, the patient. Please bring your insurance card with you each visit.

If you are covered by an insurance plan with which we do not participate or you are uninsured, payment will be expected at the time service is rendered.

MEDICARE

Physician Visits:

In some cases, we will ask you to make a decision to receive services that we expect may be denied by Medicare. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. The physician will explain why he/she feels you should receive the service. This will be done in writing on a form called an Advance Beneficiary Notice (ABN). The ABN will also provide you the opportunity to agree or refuse the services. It also explains that we will not know if the service is denied until Medicare processes the actual claim. If you have any questions, either our staff or your Medicare representative will be happy to assist you.

Acupuncture:

Acupuncture is not contractually covered by Medicare; however treatments may be covered by your secondary plan. We encourage you to contact them to verify coverage. If there is no coverage, we will ask for payment at the time services are rendered.

Please turn over

INDEPENDENT THERAPISTS

It is the responsibility of each independent therapist (massage therapist, reflexologist, shiatsu therapist) to inform you of their policy regarding insurance participation and payment options. Additionally, each independent therapist is responsible the treatment he/she provides and scheduling his/her appointments.

REFERRALS

In some cases a referral is required from the primary care provider. It is the responsibility of the patient to contact their insurance carrier to obtain specific information regarding the necessity of a referral.

CO-PAYS, DEDUCTIBLES, AND COINSURANCE

Your insurance company may require us to collect a co-pay at the time of service. Legally we cannot waive co-pays, deductibles, or co-insurance amounts.

SUPPLEMENTS, HOMEOPATHOTIC REMEDIES, PATIENT EDUCATIONAL MATERIAL

Payment for these items is expected at the time of purchase.

ACCEPTABLE FORMS OF PAYMENT & PAYMENT PLANS

We accept the following forms of payment:

- Cash
- Check
- Visa or Master Card
- Money Order

Payments should be mailed to:

University of Maryland Integrative Medicine, LLC
PO Box 64697
Baltimore, MD 21201

If you have any questions, please call 410-448-6361. Representatives are available Monday thru Friday from 8:30am to 4:30pm. Payment plans (charity care) are available under certain circumstances; however, advance notice and pre-approval is required. Please see our staff for details.

PAST DUE ACCOUNTS

Every attempt will be made, including the services of a collection agency, to collect past due accounts.

RETURNED CHECKS

A fee of \$30 will be assessed to your account for each personal check returned by your financial institution for “non-sufficient funds”. Furthermore, all future appointments will be postponed until fee is paid.

MEDICAL RECORDS

We require written requests for copies of medical records. Our fees for providing this service are in accordance with Maryland state law. See the receptionist for more details.

FORMS COMPLETION

Payment for the completion of forms (disability forms, etc.) must be made at the time of service. The fees are based on the complexity of the form.

I, _____, have both read, and fully understand the Financial Policy described above. My signature signifies that I accept the terms as set forth in this agreement.

Patient or Financially Responsible Person

Witness

Date

Date

If you would like a copy of this, please ask the receptionist. The original copy will be kept in your file.



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*Acupuncture Treatment
Patient Information*

Please read this information carefully, and ask your practitioner if there is anything that you do not understand.

What is acupuncture?

Acupuncture is a form of treatment involving the stimulation of specific points on the body by the use of needles, electricity, magnetic fields, heat, or pressure. It is a part of East Asian healing techniques that may also include the use of suction cups, regional heat or infrared energy, and tissue massage. The usual treatment session involves the insertion of thin needles into specific points on the body. In addition, acupuncture may involve oriental herbal medicine and nutritional counseling.

Is acupuncture safe?

Acupuncture is generally a safe method of treatment; however, acupuncture may have the following side effects:

- Drowsiness after treatment in a small number of patients. (If affected, you are advised not to drive immediately after your session, relax at the office before going out in traffic).
- Minor bleeding, bruising, numbness or tingling near the needling sites occurs after acupuncture in about 3% of treatments.
- Minor discomfort during needle insertion. (If pain persists more than a few seconds, tell your practitioner immediately).
- Occasionally symptoms can get worse after treatment (<3% of patients). You should tell your acupuncturist about this; however, this is usually a good sign and is referred to as “rebound phenomenon”.
- Fainting and/or dizziness can occur in certain patients, *usually those* who have had bad experiences with needling, and blood drawing. (Tell us if you have had such experiences, your practitioner can adjust your first treatment to help you avoid this happening).
- Infection. ***Single-use, sterile, disposable needles are used in the clinic to avoid the risk of infection.***
- *Organ puncture, nerve damage or tissue injuries from needles have been reported in literature; however, such injuries are unusual.*

Oriental Herbal Medicine and Nutritional Counseling:

The herbs and nutritional supplements that may be recommended to you are generally considered safe, although some may be toxic in large doses. Some herbs may be inappropriate if you are pregnant. You should consult your personal physician prior to taking any herbs if you are pregnant or are trying to become pregnant. Possible side effects of taking herbs are nausea, gas, diarrhea, vomiting, headaches, rashes and hives.

Inform your acupuncturist immediately if you experience any of the above side effects.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

Is there anything your practitioner needs to know?

Please answer the following:

| | | |
|---|-----|----|
| Are you pregnant or trying to become pregnant? | Yes | No |
| Have you ever experienced a fit, fainted or had seizures? | Yes | No |
| Do you have a pacemaker or any other electrical implants? | Yes | No |
| Do you have a bleeding disorder? | Yes | No |
| Do you have had hepatitis B, C, D or HIV infection? | Yes | No |
| Are you taking anti-coagulants or any other medication? | Yes | No |
| Do you have damaged heart valves or have any other particular risk of infection? | Yes | No |
| Do you have an abnormal breastbone or other birth defect affecting your bones, muscles or nerves. | Yes | No |

Patient Precautions:

Avoid the following for at least six hours after acupuncture treatment unless otherwise noted:

- Exercise or vigorous activity
- Heavy meals
- Alcohol consumption
- Sexual relations (for 8-12 hours)
- Sweets or heavy foods

University of Maryland Integrative Medicine, LLC

*Acupuncture Treatment
Authorization and Informed Consent for Acupuncture*

I hereby authorize University of Maryland Integrative Medicine, LLC to perform acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by acupuncturists affiliated with the Practice. I understand that acupuncture involves the stimulation of specific points on the body by the use of needles, electricity, magnetic fields, heat, or pressure and that herbal medicine and nutritional counseling may also be involved in my treatment.

I understand that this form of treatment is not a substitute for western medical treatment and that if I am under the care of a physician for a particular ailment or condition, I should continue my care until advised differently by my personal physician.

No promises or guarantees have been made about the success or results of acupuncture treatment by University of Maryland Integrative Medicine, LLC. I understand that side effects are possible. These potential complications have been explained to me in the Patient Information provided by the University of Maryland Integrative Medicine, LLC, which I have read and understand. I understand that the Patient Information describes the major risks of treatment, and that other side effects and risks may occur. I have weighed the risks and benefits of acupuncture treatment and wish to proceed. I understand that I can refuse or discontinue treatment at any time. I will notify my acupuncturist if I am or become pregnant.

I understand that I may be required to be partially undressed to receive acupuncture treatment and/or other techniques (*i.e.* Cupping, Manipulation, Tui-na massage) due to the locations of acupuncture points on the body.

In the course of treatment, if transfer to a hospital becomes necessary, I give my permission for University of Maryland Integrative Medicine, LLC to arrange for my transfer to Kernan Hospital in Baltimore, Maryland or any other appropriate hospital.

I certify that:

- I have read (or had read to me) and understand the contents of the Patient Information and this Consent;
- A licensed acupuncturist or the acupuncturist's designee has explained to me the risks and potential complications associated with acupuncture treatment;
- I have had an opportunity to ask questions and have made an informed decision to consent; and
- I intend this Consent to apply to my entire course of treatment for my present condition and for any future condition(s) for which I seek treatment from University of Maryland Integrative Medicine, LLC.

Patient Signature (Parent/Guardian)

Date

Print name in full

Witness Signature

Date