Welcome

Welcome to Holistic Health at Stonington Natural Health Center. We are so glad that you made it here. Soon you will experience a wonderful, relaxing treatment.

Here at Stonington Natural Health Center, we offer Acupuncture & Oriental Medicine Treatments, Naturopathic Medicine, the SNHC Customized Massage to your desired level of pressure incorporating Swedish and Deep Tissue Massage, Hot Stone Massage, Pregnancy Massage, and Reiki. Enjoy feeling better as you breathe more deeply and allow your mind to rest. These Holistic Therapies help you to let go of your worries. Your body, mind, and spirit will thank you for this enjoyable rejuvenating treatment.

If you are here for Massage today, your treatment may include light and deep pressure. Please let your Licensed Massage Therapist know which areas you would like to focus on. Feedback and communication are very important when establishing a relationship with your massage therapist so that she can know what pressure you like and what areas you would like to focus on. This treatment is for you, and the massage therapists appreciate feedback.

For injuries or health complaints, it is recommended to come in for treatments for a series of treatments close together, such as every two or three days or once per week. You will receive the most benefit when being treated before the effects of the previous treatment disappear. During times of stress, anxiety, or depression, it is helpful to come in for massage treatments at least once a week, and in severe cases, daily treatment is recommended. When needed, it is can be very helpful to see your massage therapist for a series of days in a row, then slowly space the treatments apart as a tune-up to maintain good health. This allows us to shift the pattern of your energy more quickly and easily and with longer lasting effects. And that's our goal: to get you better quickly and to instill long-term good health.

If you have any questions, concerns, or feedback, feel free to talk with or email us at info@snhc.com.

We appreciate this opportunity to contribute to you on your path towards optimal health and happiness.
ALL OF US AT STONINGTON NATURAL HEALTH CENTER

All life is an experiment.
The more experiments you make the better.
RALPH WALDO EMERSON

Enjoy the journey.
DEEPAK CHOPRA

Stonington Natural Health Center
***acupuncture * herbal medicine * bodywork**

FINANCIAL POLICIES FOR TREATMENT AND CARE

Holistic Medicine is excellent for helping you when you are not feeling well. If you have a cold, flu, illness or are in pain, those are the best times to come in. We prefer that you come in on time; however, if you are running late, we prefer that you arrive late rather than miss your appointment. If you need to change, reschedule, or cancel, we greatly appreciate your calling Stonington Natural Health Center as soon as you can and *at least two days, or 48 HOURS,* before your appointment.

"Minimum 48 Hours Cancellation Policy":

Your appointment time is reserved for you. **We ask for at least 48 hours notice. If LESS THAN 24 HOURS is given to Stonington Natural Health Center for rescheduling or canceling, your credit card will be charged for the appointment. Treatment packages will have one treatment deducted.**

SNHC Cancellation Policy means that if your appointment is 9 am Monday, you have **up to 24 hours before**, or 9 am Sunday, to reschedule in order not to be charged--please leave a message. We prepare our schedule days in advance, and while we know that situations arise, **this policy must exist for us to be here for you**. Thank you for understanding.

Payment: In an attempt to keep health care costs low, payment is required at the time of your service. Preferred payment methods are cash, check, Visa, Master Card, or Discover.

Treatment Plans*:* Dr. Marco or your Licensed Massage Therapist will develop your treatment plan to guide you to accomplish your goals and feel your best as soon as possible. Follow your Treatment Plan to achieve optimal results rather than experience a yo-yo effect.

Reduced Fee Treatment Packages: are available to (1) make check-out easier, (2) lower the price, and (3) make a commitment between practitioner and patient to help you complete your treatment goals. Treatment Packages are not refundable and can only be used for the services purchased. Acupuncture Treatment Packages and Massage Treatment Packages are good for a one year time period from the date of purchase and can be shared with one person.

Your credit card number is kept on file for payment of any missed or cancelled appointments, for guarantying personal checks, and when special orders are made for herbs, Gift Certificates, or if you don't bring in your wallet for your treatment – patients find this very convenient to have their credit card information on file. Your credit card information is kept private, confidential, and secure. This form is kept separate from your file in a locked safe.

The following information is required to receive treatments:

Visa/MC _____ _____/_____ _____
(Please circle) Credit Card Number Month year 3 digit code on back

I have read, I understand, and I agree to the above information:

_____ _____ _____
Signature **Printed Name** **Date**

MEGAN MARCO, D.Ac., L.Ac.
STONINGTON NATURAL HEALTH CENTER
107 WILCOX ROAD, SUITE 103
STONINGTON, CT 06378

PATIENT NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. (Health Insurance Portability and Accountability Act – "HIPAA")

Patient Rights and Uses and Disclosures of Health Information:

PERSONAL HEALTH INFORMATION DISCLOSURE:

In the course of your care as a patient at Stonington Natural Health Center, we may use or disclose personal or health related information about you in the following ways:

1. Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.

2. Your health care records, as well as your billing records, may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer, if they are or may be responsible for the payment of your services.

3. Your name and address, phone number, and your health care records may be used to contact you regarding appointment reminders, information about alternatives to your present care, Stonington Natural Health Center newsletters, or other health related information that may be of interest to you. If you are not home to receive an appointment reminder, a message may be left on your answering machine or voicemail. Further, you have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you, or the reimbursement avenues associated with your care.

PERMITTED OR REQUIRED TO USE OR DISCLOSE HEALTH INFORMATION WITHOUT YOUR CONSENT OR AUTHORIZATION:

UNDER federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.

2. If we provide health care services to you in an emergency.

3. If there are substantial barriers to communicating with you, but in our professional judgment believe that you intend for us to provide care.

4. If we are ordered by the courts or another appropriate agency.

ANY USE OR DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, OTHER THAN OUTLINED ABOVE WILL ONLY BE MADE WITH YOUR WRITTEN AUTHORIZATION

We normally provide information about your health in person at the time you receive services or care from us. We also may mail information to you regarding your health care, or about the status of your account. If you would like to receive this information at an address other than your home or, if you would like the information in a different form, please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing

PRACTIONER LEGAL DUTIES

We are required by state and federal law to maintain the privacy of your patient file and the protected health information herein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

COMPLAINTS & QUESTIONS

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities, you should direct your questions to: Megan Marco, D.Ac., L.Ac., (860) 536-3880.

This notice is effective immediately. This notice, and any alternation or amendments made hereto, will expire seven (7) years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____ _____

Patient Name (printed) Signature

_____

DATE

Client Intake Form

Please be aware that massage therapists abide by a code of ethics that ensures and protects client confidentiality; no information about a client is shared or disclosed unless the client gives informed consent.

Name_____ Today's date_____

Email address (for specials & events) _____

Address _____

Please circle which number you prefer to be contacted at:

Home number_____ Work number_____ Cell number_____

Employed By_____Occupation/Profession_____

Date of birth _____Age_____ Referred By_____

Emergency Contact _____Phone #_____Relationship_____

Significant other or Spouse's Name_____

Ages of Children & Names_____

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Have you had a massage before? _____When?_____

Reason for today's visit: _____

Any areas you would like me to avoid? (i.e. ticklish areas) _____

Do you wear contact lenses and or hearing aid? _____

# of glasses of water per day _____ Hours of sleep? _____ Are your bowels regular? _____

Do you have reason to believe you may be pregnant? Y / N Due date_____

Do you belong to a fitness facility? Y/ N

List any recent injuries, surgeries, accidents or medical treatments? _____

_____

_____

Pain and discomfort can be traced back to many different origins. Please describe your complaint below, and mark the affected area(s) on the figure shown here:

_____

_____

_____

_____

_____

Please list any allergies you may have:

_____

Are you presently taking medication or supplements? Y / N If yes, please include:

_____

_____

Please Check any of the following conditions:

Musculoskeletal

- ❑ Fibromyalgia
- ❑ Spasms/Cramps
- ❑ Sprains/Strains
- ❑ Osteoporosis
- ❑ Postural Deviations
- ❑ Gout
- ❑ Osteoarthritis/Rheumatoid Arthritis
- ❑ TMJ
- ❑ Cysts
- ❑ Bursitis
- ❑ Plantar Fascitis
- ❑ Tendonitis
- ❑ Whiplash Syndrome
- ❑ Carpal Tunnel
- ❑ Headache
- ❑ Leg Pain
- ❑ Arm/Shoulder Pain
- ❑ Lower Back Pain
- ❑ Mid Back Pain
- ❑ Hip Pain
- ❑ Other _____

Respiratory

- ❑ Pneumonia
- ❑ Sinusitis
- ❑ Asthma
- ❑ Trouble Breathing
- ❑ Dizziness

Circulatory

- ❑ Anemia
- ❑ Hemophilia
- ❑ Hypertension
- ❑ Low blood pressure
- ❑ Raynaud's Disease
- ❑ Varicose Veins
- ❑ Heart Condition
- ❑ Blood Clots/Phlebitis
- ❑ Diabetes
- ❑ Edema
- ❑ Other _____

Digestive

- ❑ Ulcers
- ❑ Irritable Bowel Syndrome
- ❑ Colitis
- ❑ Hepatitis
- ❑ Gallstones
- ❑ Chron's Disease
- ❑ Diarrhea
- ❑ Gas/Bloating
- ❑ Indigestion
- ❑ Other _____

Skin

- ❑ Fungal Infections
- ❑ Acne
- ❑ Impetigo
- ❑ Dermatitis/Eczema
- ❑ Psoriasis
- ❑ Open Wounds or Sore
- ❑ Rashes
- ❑ Warts/Moles
- ❑ Athletes Foot
- ❑ Other _____

Nervous System

- ❑ ALS
- ❑ Multiple Sclerosis
- ❑ Parkinson' Disease
- ❑ Bell's Palsy
- ❑ Spinal Cord Injury
- ❑ Seizure Disorders
- ❑ Numbness/Tingling/Twitching
- ❑ Other _____

Other

- ❑ Insomnia
- ❑ Anxiety/Panic Attacks
- ❑ Grief Process
- ❑ Cancer
- ❑ Substance Abuse
- ❑ Chronic Fatigue
- ❑ HIV/AIDs
- ❑ Lupus
- ❑ Kidney disease
- ❑ Bladder Infection
- ❑ Other _____

Are you currently under a doctor's care? ___ Doctor's Name and number_____

The above information is accurate to the best of the knowledge. I understand that massage therapists are neither trained nor licensed to provide medical treatment, diagnose, prescribe medications, perform spinal or joint manipulation, nor any other service for which a license to practice medicine, chiropractic, naturopathy, physical therapy or podiatry is required by law. I understand that massage therapy is not a substitute for medical attention or examination. I assume full responsibility for alerting the practioner to any changes to my health. I am responsible for payment for services rendered.

Client Signature _____ Date _____