ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic

The Springs Integrative Medicine Center and Spa – New Client Form

NEW CLIENT REGISTRATION - PLEASE PRINT ALL REQUESTED INFORMATION CLEARLY

_____ _____ _____
PATIENT LEGAL NAME DATE OF BIRTH AGE

GENDER: □MALE □FEMALE HEIGHT _____ WEIGHT _____ MARITAL STATUS: □MARRIED □SINGLE □WIDOWED □DIVORCED

_____
ADDRESS CITY STATE ZIP

_____ _____
OCCUPATION EMPLOYER

( )_____ ( )_____ ( )_____EXT:_____
HOME PHONE CELL PHONE WORK PHONE

□ CHECK BOX IF YOU WOULD LIKE TEXT MESSAGE REMINDERS FOR APPOINTMENTS **– PLEASE NOTE: YOU CANNOT CANCEL APPOINTMENTS VIA TEXT**

_____ _____
PARENT/GUARDIAN/LEGALLY RESPONSIBLE PARTY NAME (IF APPLICABLE) RELATIONSHIP

EMERGENCY CONTACT NAME_____ PHONE: ( )_____

HOW DID YOU HEAR ABOUT THE SPRINGS? _____

IF YOU WOULD LIKE TO RECEIVE EMAILS FROM THE SPRINGS, WE SEND – APPOINTMENT *REMINDERS, NEWS, EDUCATIONAL ARTICLES, SALES & PROMOTIONS VIA EMAIL.* *You may choose to unsubscribe at any time and your information will never be sold or shared with any other list.*
EMAIL:

ACKNOWLEDGEMENT OF POLICIES - By signing below, I acknowledge that I understand the following policies:

- I will be required to **provide credit card information** to hold appointment times, **or prepay** for the scheduled service. You may pay for the service in any format you choose. We accept cash, checks, all major credit cards, and Spa Finder Gift Certificates.
- **Late Cancellation Policy:** Any late cancellation will incur a charge of 50% of the full session fee. We require 24 hours notice to cancel or reschedule without incurring the 50% fee. Exceptions to the late cancellation policy may be granted at the discretion of the manager.
- **No Show Policy:** No shows will be charged 100% of the service fee for the scheduled appointments missed.
- There is a $25 fee for returned checks.
- Payment is due at the time of treatment. I will be responsible for full payment for my service, even if I am late for my appointment. It is my responsibility to arrive on time.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

INSURANCE INFORMATION – ACUPUNCTURE (DO NOT USE FOR WORKER'S COMP OR NO FAULT)

□ *I UNDERSTAND THAT INSURANCE COVERAGE FOR ACUPUNCTURE IS LIMITED & I HAVE CONTACTED MY INSURANCE COMPANY TO VERIFY COVERAGE AND POLICY LIMITS UNDER MY PLAN. I UNDERSTAND THAT I MAY HAVE A COPAY OR COINSURANCE AMOUNT DUE FOR EACH APPOINTMENT.*

_____ _____
NAME OF SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH

_____ ( )_____
RELATIONSHIP TO PATIENT SUBSCRIBER PHONE NUMBER

_____ _____
NAME OF INSURANCE CARRIER/PLAN SUBSCRIBER ID# (INCLUDE ALL LETTERS & NUMBERS)

PLEASE PRESENT YOUR INSURANCE CARD AT THE TIME OF YOUR VISIT.

COVID-19 Safety Guidelines:

- For up-to-date information on symptoms, prevention, and other community resources, please visit https://www.rochesterregional.org/coronavirus-covid19
- **You MUST wear a mask - it must cover both your nose and mouth.** Our practitioners wear PPE for all appointments.
- **Arrive AT your appointment time**. You may be asked to wait outside the hospital building until your appointment time if you arrive early. You may call from the parking lot to see if we can accommodate you before your scheduled time.
- If you have **any symptoms of illness, please call to reschedule**. There will be no fee for cancelling if you are ill.
- If you travel to any state on the NY Travel Advisory, please do not schedule an appointment at The Springs until you have completed the mandatory quarantine process.

If you have any of the following symptoms, please contact us immediately to cancel:

- Loss of sense of taste or smell
- Chills or Fever over 100F (37.8C)
- Sore throat (not due to allergies)
- Feeling like you are coming down with illness (fatigue or muscle aches that are unusual for you)
- Contact with a confirmed case of COVID-19 in past 2 weeks
- New cough/change in cough
- New or worsening shortness of breath/difficulty breathing
- Unusual headache or eye pain
- Abdominal pain, nausea, vomiting, diarrhea, loss of appetite
- Self has tested positive for COVID-19 in past 2 weeks

The Springs follows CDC, DOH, OSHA, Rochester Regional Health Infection Prevention, & NYS Executive Order Guidelines for the safety of our staff and guests. *I confirm and understand the following (Initial in all places provided):*

_____ Initial Here	I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.
_____ Initial Here	I understand that I am the decision maker for my health care. To the best of their ability, my practitioner(s) will provide me with information to assist me in making informed choices regarding the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.
_____ Initial Here	I understand that preventative measures and intensified sanitation protocols intended to reduce the spread of COVID-19 have been implemented. However, because this work involves close physical proximity over an extended period of time in a closed space, there may be an elevated risk of disease transmission, including COVID-19. I hereby acknowledge and assume the risks associated with COVID-19 and give my express permission to you and the staff at your offices to proceed with providing care.
_____ Initial Here	I agree to communicate concerns with my practitioner(s) as they arise. Infection with COVID-19 may result in long term side effects that are not well understood at this time. I agree to notify my practitioners if I become infected with COVID-19 and recover so that any precautions for specific services may be implemented for my safety.
_____ Initial Here	I intend this consent to cover the entire course of care from all practitioners in this office for my present condition(s) and any future condition(s) for which I seek care from this office. I knowingly and willingly consent to treatment with the full understanding and disclosure of risks associated with receiving care during the pandemic.

_____ _____
PRINT PATIENT NAME DATE OF BIRTH

_____ _____ _____
PATIENT/PARENT/GUARDIAN SIGNATURE RELATIONSHIP DATE SIGNED

IF YOU ARE CONSENTING FOR A MINOR, OR A PATIENT UNABLE TO GRANT PERMISSION THEMSELVES, PLEASE COMPLETE THE FOLLOWING:

☐ PATIENT IS A MINOR UNDER THE AGE OF 18

☐ PATIENT IS UNABLE TO UNDERSTAND BENEFITS AND/OR RISKS OF CONSENTING OR NOT CONSENTING TO TREATMENT(S) AND CONSENT IS PROVIDED BY PARENT/GUARDIAN

_____
PRINT PARENT/GUARDIAN NAME

NAME _____ **DATE OF BIRTH** _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

NAMES OF MEDICAL SPECIALISTS WHO TREAT YOU & WHY DO YOU SEE HIM OR HER?

_____

_____

WHAT IS THE PRIMARY REASON YOU ARE SEEKING TREATMENT AT THE SPRINGS? _____

DO YOU HAVE ANY PAIN? *- please include recent pain history even if you are not in pain today.* ☐YES ☐NO DESCRIBE YOUR PAIN: _____

_____

_____

DO YOU HAVE TROUBLE MOVING ANY JOINTS? ☐YES ☐NO WHAT JOINTS OR MOVEMENTS ARE RESTRICTED? _____

_____

WHAT ARE YOUR MAJOR SOURCES OF STRESS? 1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

DO YOU HAVE A BLEEDING DISORDER? ☐YES ☐NO

DO YOU TAKE/USE ANY OF THE FOLLOWING MEDICATIONS?

PRESCRIPTION BLOOD THINNERS (EX. COUMADIN, WARFARIN, HEPARIN)? ☐YES ☐NO

ARE YOU TAKING ANY MEDICATIONS THAT ALTER YOUR MENTAL STATUS? ☐YES ☐NO

ALLERGIES

DRUGS/MEDICATIONS	☐YES	☐NO	SPECIFY:
GLUTEN	☐YES	☐NO	SPECIFY:
IODINE/SEAFOOD	☐YES	☐NO	SPECIFY:
OTHER FOODS	☐YES	☐NO	SPECIFY:
PLANTS/ENVIRONMENTAL	☐YES	☐NO	SPECIFY:
OTHER	☐YES	☐NO	SPECIFY:
SKIN SENSITIVITIES/REACTIONS TO PRODUCTS/INGREDIENTS	☐YES	☐NO	SPECIFY:

MAIN MEDICAL HISTORY (PLEASE INCLUDE DATES):

MEDICAL DIAGNOSES:

SURGERIES OR INJURIES:

PLEASE LIST PRESCRIPTION & OVER THE COUNTER MEDICATIONS:	PLEASE LIST HERBS, SUPPLEMENTS, VITAMINS, ETC:
YOU MAY PROVIDE US WITH A COPY OF YOUR MEDICATIONS & SUPPLEMENTS IF LIST IS EXTENSIVE	

DO YOU HAVE NOW, OR IN THE PAST ANY OF THE FOLLOWING:

CONDITION/SYMPTOM	YES	COMMENTS/DETAILS
DIABETES	☐	
MEMORY LOSS	☐	
LIGHT HEADED/DIZZY/VERTIGO	☐	
FAINTING/LOSS OF BALANCE	☐	
FALLS	☐	
BLOOD CLOTS OR PHLEBITIS	☐	
HEART DISEASE	☐	
HIGH BLOOD PRESSURE	☐	
LOW BLOOD PRESSURE	☐	
HAVE YOU HAD A STROKE?	☐	
SWELLING/EDEMA	☐	
OSTEOPOROSIS/OSTEOPENIA	☐	

CONDITION/SYMPTOM	NOW	PAST
CANCER	☐	☐

TYPE: _____
WHEN: _____
TREATMENT: _____

LYMPH NODES REMOVED? Y☐ N☐
HOW MANY? _____
WHICH NODES? _____

THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM MY PRACTITIONER OF ANY CHANGES IN MY HEALTH PRIOR TO TREATMENT.

_____ _____
PATIENT SIGNATURE DATE