Shalem Healing.

Demographic Information: **Today's Date**: _____

Name (First, Middle Initial, and Last):

_____

Date of Birth: _____/_____/_____

Gender: _____

Address:

_____

City:_____ State: _____ Zip Code:_____

Telephone Number: _____

Email Address:_____

Emergency Contact(Name, Relation to you and Phone number):

_____

_____

Name, Clinic Name, and Phone Number of Primary Care Physician, If Applicable:

_____

_____

I Verify That This Information is Correct:

_____

Signature.

Insurance Information.

Primary Insurance:

Name of Insurance:_____

Insurance ID#: _____

Group Number: _____

Name and Date of Birth of Primary Policy Holder:_____

Your Relationship to the Primary Policy Holder:_____

When Did You Start This Insurance:_____

Co-Pay Dollar Amount: $_____

Secondary Insurance:

Name of Insurance:_____

Insurance ID#: _____

Group Number: _____

Name and Date of Birth of Primary Policy Holder:_____

Your Relationship to the Primary Policy Holder:_____

When Did You Start This Insurance:_____

Co-Pay Dollar Amount: $_____

I Verify That This Information Is Correct:

_____

Signature.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby give my consent for Shalem Healing to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices is provided by Shalem Healing and describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Shalem Healing reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices can be requested in the office or via email at any time by writing to contact@shalemhealing.org.

With this consent, Shalem Healing may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test result, among others.

With this consent, Shalem Healing may send mail to my home or other alternative location if it assists the practice in carrying out health care operations, such as patient billing statements or requested lab results as long as it is marked "Personal and Confidential."

With this consent, Shalem Healing may send e-mails that assist the practice in carrying out TPO, such as appointment reminders, requested lab results or information related to my clinical care.

I have the right to request that Shalem Healing restrict how it uses or discloses my PHI to carry out TPO and I will specify this below (please include names of anybody we can and/or cannot share health information with).

I authorize Shalem Healing to release my records and any information requested to the following individuals.

1._____ Relation to Patient:_____ Release __ Do Not Release __

2._____ Relation to Patient:_____ Release __ Do Not Release __

3._____ Relation to Patient:_____ Release __ Do Not Release __

By signing this form, I am consenting to allow Shalem Healing to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Shalem Healing may decline to provide treatment to me if they are unable to deliver care while honoring my privacy requests.

Printed Name of Patient or Legal Guardian_____

Signature of Patient or Legal Guardian _____ Date _____

Shalem Healing Fee Policy

At Shalem Healing we offer truly integrative holistic care. We integrate Traditional Chinese Medicine, Nursing Science, Nutritional Science, and Western Medicine for your health. Each of these disciplines has its place in health care. At times herbal medicine is the best, at times counseling, at times nutriceuticals, and at times pharmaceuticals. We use our experience to provide the least invasive, most effective care/treatment we can offer. We offer pediatric care, woman's health care, and family practice. We believe that everyone deserves competent medical care and do not refuse treatment based on finances or insurance coverage.

We will bill your insurance company if you are insured. Our out of pocket fees are 80% of the Medicare Reimbursement Rate and varies based on the complexity of the visit.
The fees are as follows:

Initial Visit Rate: $61.00-$167.00
Follow-up Visit Range: $35.00-$118.00
Acupunture Follow-up: $54.00

Most insurance plans do not cover acupuncture. We do not bill your insurance for acupuncture, only medical consultation (depending on your plan). If you have a reason to believe that your plan will cover acupuncture, please verify this with them before the visit. All such visits not covered by your plan will need to be paid in the office at the time of the visit. If you fall below the federal poverty level, have Medicare, Medicaid, or Social Security Disability you will pay $18.00 for acupuncture.

We reserve the right to bill your insurance or charge out of pocket fee for phone consultation. You will be charged for phone consultations with a registered nurse if the assessment and management services provided do not directly originate from a visit within the previous seven days or leading to an appointment in the following 24 hours or soonest available appointment. You will not be charged for a phone consultation under 5 minutes. Fees will vary based on the length of the phone call after 5 minutes.

If you have questions or concerns regarding our billing policies you may call the office at 414-640-5433.

Signature: _____ **Date:** _____

Authorization for Disclosure of Medical Records

Patient to Complete:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

I authorize the release of my medical records in accordance with the specification listed below. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

Records Released to:

Shalem Healing, Inc | 3338 N Dr Martin Luther King Jr Drive, Milwaukee, WI 53212

Phone: 414-640-5433 | Fax: 414-502-0192

Records Released From: *(check all that apply)*

Clinic/Facility/Provider(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released:

- ▢ Complete Copy of All Records
- ▢ Lab Reports
- ▢ Allergy Records
- ▢ Immunizations Records
- ▢ Counseling Visits
- ▢ Imaging Reports
- ▢ Other _____

For the Following Dates: _____ to _____

In compliance with Wisconsin Statutes which require special permission to release otherwise privileged information, please release records pertaining to: (check all that apply)

- ▢ Mental Health
- ▢ Payment of Insurance Claims
- ▢ Legal Investigation
- ▢ Other _____

This authorization will remain in effect until the request is processed unless you specify this authorization wil be effective for an additional time period. Written consent is necessary to revoke this request.

- ▢ Additional Time Period - Specify date(s): _____
- ▢ None
- ▢ Include future records generated during the additional time period

Signature: _____ Date: _____

Shalem Healing

3338 N Dr. Martin Luther King Jr. Dr., Milwaukee, WI 53212 | (P) 414-640-5433 | (F) 414-502-0192 | www.shalemhealing.org

General Informed Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist, and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient, Personal Representative, or Legal Guardian (if patient is a minor)

Date:

_____ _____

Printed name of Patient, Personal Representative, or Legal Guardian (if patient is a minor)

Relationship to Patient

Shalem Healing

3338 N Dr. Martin Luther King Jr. Dr., Milwaukee, WI 53212 | (P) 414-640-5433 | (F) 414-502-0192 | www.shalemhealing.org

TELEMEDICINE CONSENT FORM

Telemedicine services may be offered as sole or partial treatment. Telemedicine services involve the use of audio, live video (like Skype, Zoom, Etc.,), or other electronic communications to interact with you for the purpose of providing medical care, and/or follow-up services on an individual basis. A potential risk of telemedicine is that your specific concerns, or unforeseen technical issues, may still necessitate a face-to-face session as part of your ongoing treatment.

Additionally, in **RARE circumstances** security protocols could fail causing a breach of patient privacy. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consultation without affecting your right to future care or treatment. The alternative to telemedicine is a face-to-face visit with a clinician.

I do hereby consent to allow my provider to record any or all parts of my telehealth session(s). This includes video and/or audio recording of any conversations, consultations and virtual treatments/office visits.

I understand that the recordings of my telehealth sessions and virtual communications are for the sole use of my treatment and medical documentation, and will not be used in any marketing or advertising; nor will they be used as patient testimonials without my express written consent.

I understand that I have a right to request copies of such recordings and have the right to revoke this authorization in writing at any time during the course of my treatment.

I understand that this authorization will remain in place in perpetuity, or until such time as I revoke the authorization in writing.

Patient Name: _____ Date: _____

Patient Signature:

_____

Shalem Healing

Medical History Form

Today's Date: _____

Patient Name: _____

Preferred Name:_____

Date of Birth: _____

Current Occupation: _____

Current Tobacco user:

If **yes**, please fill out below:	If **no**, please fill out below:
How many packs day: ____ How many years:_____	No: _____ quit date:_____ how many packs per day: _____

Any Alcohol use: No _____

If **yes,** please fill out below:
of beers/week_____
of liquor beverages/week_____
of wine/week_____

Any use of marijuana or other recreation drugs? Yes:___ No:___

If yes, please be specific: _____

Major Events or Surgeries: please list below:

Name of Surgery or major event:	Year it occurred:

Do you have OR have you ever had: Please check one.

- Anxiety/Depression/bipolar Yes: __ No: __ if yes Specifics: _____
- Arthritis. Yes: __ No: __ if yes Specifics: _____
- Asthma Yes: __ No: __ if yes Specifics: _____
- Bleeding Disorders Yes: __ No: __ if yes Specifics: _____
- Blood Clots Yes: __ No: __ if yes Specifics: _____
- GI/Intestinal Problems. Yes: __ No: __ if yes Specifics: _____
- Diabetes. Yes: __ No: __ if yes Specifics: _____
- Glaucoma/eye problems. Yes: __ No: __ if yes Specifics: _____
- Hearing problems. Yes: __ No: __ if yes Specifics: _____
- Heart attack/Disease. Yes: __ No: __ if yes Specifics: _____
- High Blood Pressure. Yes: __ No: __ if yes Specifics: _____
- High Cholesterol Yes: __ No: __ if yes Specifics: _____
- HIV/AIDS. Yes: __ No: __ if yes Specifics: _____
- STI's Yes: __ No: __ if yes Specifics: _____
- Kidney Disease. Yes: __ No: __ if yes Specifics: _____
- Liver Disease. Yes: __ No: __ if yes Specifics: _____
- Lung Disease. Yes: __ No: __ if yes Specifics: _____
- Mental Health problems. Yes: __ No: __ if yes Specifics: _____
- Seizures Disorder Yes: __ No: __ if yes Specifics: _____
- Skin Problems. Yes: __ No: __ if yes Specifics: _____
- Stroke. Yes: __ No: __ if yes Specifics: _____
- Thyroid Disorders. Yes: __ No: __ if yes Specifics: _____
- Hepatitis Yes: __ No: __ if yes Specifics: _____
- Cancer Yes: __ No: __ if yes Specifics: _____
- Implants/medical devices Yes: __ No: __ if yes Specifics: _____
- Other. if yes Specifics: _____
- Other. if yes Specifics: _____

Are you allergic to any of the following medications: Please list foods or environmental allergies as well.

- Aspirin Yes: __ No: __ if yes reaction:_____
- Penicillin Yes: __ No: __ if yes reaction:_____
- Codeine Yes: __ No: __ if yes reaction:_____
- Latex Yes: __ No: __ if yes reaction:_____
- Sulfa Drugs Yes: __ No: __ if yes reaction:_____
- Others Type:_____ reaction:_____
- Others Type:_____ reaction:_____
- Others Type:_____ reaction:_____
- Others Type:_____ reaction:_____
- Others Type:_____ reaction:_____
- Others Type:_____ reaction:_____
- Others Type:_____ reaction:_____

Medications: Please fill out below:

Medication Name:	Dose:	Directions & how often:

Supplements: Please fill out below:

Supplement/Vitamin name:	Dose:	Directions & how often:

Nutrition history:

Any special diet such as Kosher, Vegetarian, Vegan etc.… **please list here**:_____

Then please list what you typically have for the following:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Family Health History:

Please fill out anything that would run on either side of your family such as high blood pressure, asthma, heart disease etc…

Mother:_____

Father:_____

Siblings:_____

Some examples would be:

• Anxiety/Depression/ bipolar • Arthritis • Asthma • Bleeding Disorders • Blood Clots • GI/Intestinal Problems • Diabetes • Glaucoma/eye problems	• Hearing problems • Heart attack/Disease • High Blood Pressure • High Cholesterol • HIV/AIDS • STI's • Kidney Disease • Liver Disease • Lung Disease • Mental Health problems	• Seizures Disorder • Skin Problems • Stroke • Thyroid Disorders • Hepatitis • Cancer • Implants/medical devices

Do you feel safe at home?	Yes: ____ No: ____
Any past or current thoughts about harming yourself or others?	Yes: ____ No: ____
Any plans to harm yourself or others?	Yes: ____ No: ____
Do you wish to speak with someone about your home environment?	Yes: ____ No: ____
Do you wish to have any assistance with any of the above?	Yes: ____ No: ____

Patient signature:_____

Date: _____