

**Awaken**  
**Integrative Health Centers**  
www.awakenorlando.com

**Confidential Health History Questionnaire**

Date: \_\_\_\_\_

We look forward to helping you achieve your health goals. Please help us learn more about you so that we may provide you with the most effective care. On this questionnaire, you will find many in-depth questions; each answer provides important information that allows us to optimize your health care results. Thank you for your thorough responses.

Last Name		First Name		Middle Initial	Nickname	
Street Address			City		State	Zip
Home Phone	Cell Phone		Date of Birth	Age	Sex	Marital Status
Work Phone	Employer & Occupation		Emergency Contact: Name & Phone			
Height	Weight	Blood Pressure		Date of BP Reading	Blood Type	
E-mail Address (for articles and newsletters)			How did you hear about us?			
Are you currently under a Medical Doctor's care?		MD's Name		MD's Phone		
List your reasons for today's visit, in order of importance.						
What treatments have you tried or are you currently doing for these conditions?						
<b>Check if you have a <u>FAMILY HISTORY</u> of any of these:</b>						
<ul style="list-style-type: none"> <li>• Allergies</li> <li>• Arthritis</li> <li>• Asthma</li> <li>• Bleeding disorders</li> <li>• Cancer</li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Epilepsy / Seizures</li> <li><input type="checkbox"/> Glaucoma</li> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> High blood pressure</li> </ul>		<ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney disease</li> <li><input type="checkbox"/> Mental illness</li> <li><input type="checkbox"/> Stroke</li> <li><input type="checkbox"/> Thyroid disease</li> <li><input type="checkbox"/> Other inheritable disease _____</li> </ul>		

**Please identify current symptoms by marking the box under the “Now” column.  
Mark the “Past” column only if a past condition was particularly severe or significant.**

Past Now	Past Now	Past Now
<input type="checkbox"/> <input type="checkbox"/> Abdominal / stomach pain <input type="checkbox"/> <input type="checkbox"/> Abnormal appetite <input type="checkbox"/> <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> <input type="checkbox"/> Belching <input type="checkbox"/> <input type="checkbox"/> Heartburn / reflux <input type="checkbox"/> <input type="checkbox"/> Gas <input type="checkbox"/> <input type="checkbox"/> Constipation <input type="checkbox"/> <input type="checkbox"/> Diarrhea <input type="checkbox"/> <input type="checkbox"/> Black stool <input type="checkbox"/> <input type="checkbox"/> Blood in stool <input type="checkbox"/> <input type="checkbox"/> Mucous in stool <input type="checkbox"/> <input type="checkbox"/> Undigested food in stool <input type="checkbox"/> <input type="checkbox"/> Rectal pain / hemorrhoids <input type="checkbox"/> <input type="checkbox"/> Regular laxative use <input type="checkbox"/> <input type="checkbox"/> Unusually thirsty <input type="checkbox"/> <input type="checkbox"/> Overweight <input type="checkbox"/> <input type="checkbox"/> Weight changes	<input type="checkbox"/> <input type="checkbox"/> Chills <input type="checkbox"/> <input type="checkbox"/> Fever <input type="checkbox"/> <input type="checkbox"/> Excessive sweating <input type="checkbox"/> <input type="checkbox"/> Lack of perspiration <input type="checkbox"/> <input type="checkbox"/> Hot flashes <input type="checkbox"/> <input type="checkbox"/> Night sweats <input type="checkbox"/> <input type="checkbox"/> Cold Hands/Feet/Nose <input type="checkbox"/> <input type="checkbox"/> Tendency to be too hot <input type="checkbox"/> <input type="checkbox"/> Tendency to be too cold	<input type="checkbox"/> <input type="checkbox"/> Anger <input type="checkbox"/> <input type="checkbox"/> Anxiety <input type="checkbox"/> <input type="checkbox"/> Depression <input type="checkbox"/> <input type="checkbox"/> Fear <input type="checkbox"/> <input type="checkbox"/> Frustration <input type="checkbox"/> <input type="checkbox"/> Grief or sadness <input type="checkbox"/> <input type="checkbox"/> Irritability <input type="checkbox"/> <input type="checkbox"/> Mood swings <input type="checkbox"/> <input type="checkbox"/> Obsession <input type="checkbox"/> <input type="checkbox"/> Panic Attacks <input type="checkbox"/> <input type="checkbox"/> Stress <input type="checkbox"/> <input type="checkbox"/> Worry
<input type="checkbox"/> <input type="checkbox"/> Bleeding / bruising easily <input type="checkbox"/> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> <input type="checkbox"/> Poor circulation <input type="checkbox"/> <input type="checkbox"/> Dizzy spells or fainting <input type="checkbox"/> <input type="checkbox"/> Chest pain / pressure <input type="checkbox"/> <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> <input type="checkbox"/> Palpitations / chest fluttering <input type="checkbox"/> <input type="checkbox"/> Pounding heart beat <input type="checkbox"/> <input type="checkbox"/> Racing heart beat	<input type="checkbox"/> <input type="checkbox"/> Dry eyes <input type="checkbox"/> <input type="checkbox"/> Eye pain <input type="checkbox"/> <input type="checkbox"/> Itchy eyes <input type="checkbox"/> <input type="checkbox"/> Tearing eyes <input type="checkbox"/> <input type="checkbox"/> Poor vision <input type="checkbox"/> <input type="checkbox"/> Night or color blindness <input type="checkbox"/> <input type="checkbox"/> Earaches <input type="checkbox"/> <input type="checkbox"/> Ringing or sounds in ears <input type="checkbox"/> <input type="checkbox"/> Hearing problems <input type="checkbox"/> <input type="checkbox"/> Sinus problems <input type="checkbox"/> <input type="checkbox"/> Sneezing <input type="checkbox"/> <input type="checkbox"/> Snoring <input type="checkbox"/> <input type="checkbox"/> Nose bleeds <input type="checkbox"/> <input type="checkbox"/> Dry mouth or throat <input type="checkbox"/> <input type="checkbox"/> Sore throat <input type="checkbox"/> <input type="checkbox"/> Swollen glands <input type="checkbox"/> <input type="checkbox"/> Frequent hoarseness <input type="checkbox"/> <input type="checkbox"/> Mouth or lip sores <input type="checkbox"/> <input type="checkbox"/> Many cavities or root canals <input type="checkbox"/> <input type="checkbox"/> Unusual taste in mouth <input type="checkbox"/> <input type="checkbox"/> Teeth grinding or clenching <input type="checkbox"/> <input type="checkbox"/> Jaw Problems or TMJ <input type="checkbox"/> <input type="checkbox"/> Facial pain <input type="checkbox"/> <input type="checkbox"/> Headaches	<input type="checkbox"/> <input type="checkbox"/> Victim of Child Abuse <input type="checkbox"/> <input type="checkbox"/> Victim of Domestic Abuse <input type="checkbox"/> <input type="checkbox"/> Victim of Sexual Abuse <input type="checkbox"/> <input type="checkbox"/> War Veteran  <input type="checkbox"/> <input type="checkbox"/> Acne pimples <input type="checkbox"/> <input type="checkbox"/> Dry skin / Oily Skin <input type="checkbox"/> <input type="checkbox"/> Itching or burning skin <input type="checkbox"/> <input type="checkbox"/> Skin rash or sores <input type="checkbox"/> <input type="checkbox"/> Tendency to get hives <input type="checkbox"/> <input type="checkbox"/> Scalp itching or flaking <input type="checkbox"/> <input type="checkbox"/> Early graying of hair <input type="checkbox"/> <input type="checkbox"/> Loss of hair <input type="checkbox"/> <input type="checkbox"/> Nail fungus <input type="checkbox"/> <input type="checkbox"/> Weak / brittle nails
<input type="checkbox"/> <input type="checkbox"/> Chronic cough <input type="checkbox"/> <input type="checkbox"/> Coughing blood <input type="checkbox"/> <input type="checkbox"/> Frequent chest colds <input type="checkbox"/> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> <input type="checkbox"/> Tightness of chest <input type="checkbox"/> <input type="checkbox"/> Wheezing <input type="checkbox"/> <input type="checkbox"/> Coughing up Phlegm Color of Phlegm _____	<input type="checkbox"/> <input type="checkbox"/> Blood in urine <input type="checkbox"/> <input type="checkbox"/> Burning or painful urination <input type="checkbox"/> <input type="checkbox"/> Difficult urination / retention <input type="checkbox"/> <input type="checkbox"/> Frequent or urgent urination <input type="checkbox"/> <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> <input type="checkbox"/> Loss of bladder control	<input type="checkbox"/> <input type="checkbox"/> Numbness or tingling <input type="checkbox"/> <input type="checkbox"/> Poor concentration <input type="checkbox"/> <input type="checkbox"/> Poor memory <input type="checkbox"/> <input type="checkbox"/> Seizures or convulsions <input type="checkbox"/> <input type="checkbox"/> Shaking or trembling <input type="checkbox"/> <input type="checkbox"/> Stuttering or stammering  <input type="checkbox"/> <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> <input type="checkbox"/> Waking up frequently <input type="checkbox"/> <input type="checkbox"/> Wake up still tired <input type="checkbox"/> <input type="checkbox"/> Many dreams <input type="checkbox"/> <input type="checkbox"/> Nightmares
<b>LIFESTYLE &amp; DIET</b>		
<input type="checkbox"/> Tobacco <input type="checkbox"/> Marijuana <input type="checkbox"/> Other _____	<input type="checkbox"/> Other Recreational Drugs <input type="checkbox"/> High Stress <input type="checkbox"/> Occupational Hazards	Exercise: (describe)
<input type="checkbox"/> Coffee <input type="checkbox"/> Soft Drinks <input type="checkbox"/> Energy Drinks <input type="checkbox"/> Sugar <input type="checkbox"/> Fast Food <input type="checkbox"/> Alcohol (amt): _____	<input type="checkbox"/> Artificial Sweeteners <input type="checkbox"/> Vegetarian/ Vegan (circle one) <input type="checkbox"/> Low Carb <input type="checkbox"/> Low Fat <input type="checkbox"/> Paleo/Atkins/Keto (circle one) <input type="checkbox"/> Crave Sugar <input type="checkbox"/> Crave Salt	Herbs/Vitamins/Supplements: (list)

**FORMEN**

<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Genital pain, swelling or itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal sex drive [high] [low]</p> <p><input type="checkbox"/> <input type="checkbox"/> Erectile dysfunction</p>	<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Low sperm count / motility / morphology</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Penile discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Prostate problem (PSA:_____)</p>
---	---

**FOR WOMEN**

<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal PAP smear</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal sex drive [high] [low]</p> <p><input type="checkbox"/> <input type="checkbox"/> Abortion history</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast lumps / tenderness</p> <p><input type="checkbox"/> <input type="checkbox"/> Clots in menstrual blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Difficulty conceiving</p>	<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Endometriosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Fibroids</p> <p><input type="checkbox"/> <input type="checkbox"/> Genital pain, swelling or itching</p> <p><input type="checkbox"/> <input type="checkbox"/> Heavy bleeding with periods</p> <p><input type="checkbox"/> <input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> <input type="checkbox"/> Menopausal symptoms</p> <p><input type="checkbox"/> <input type="checkbox"/> Miscarriage</p>	<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Ovaries removed</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain with intercourse</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful periods</p> <p><input type="checkbox"/> <input type="checkbox"/> Pelvic inflammatory disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Polycystic ovary disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Premenstrual tension / PMS</p> <p><input type="checkbox"/> <input type="checkbox"/> Vaginal discharge or dryness</p>
--	--	---

Are you currently pregnant or trying to become pregnant?

Full length of cycle (onset to onset):	Number of pregnancies you've had:
--	-----------------------------------

Duration of periods:	Number of births you've had:
----------------------	------------------------------

Date last period began (day 1):	Ages of your children:
---------------------------------	------------------------

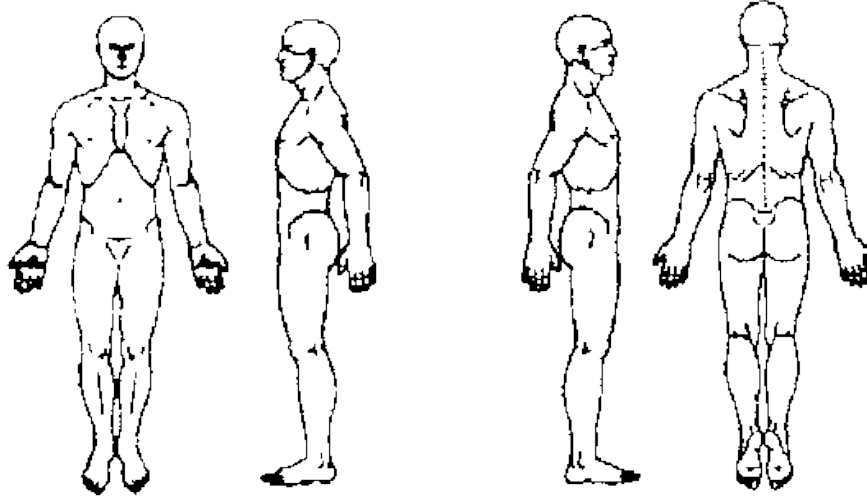
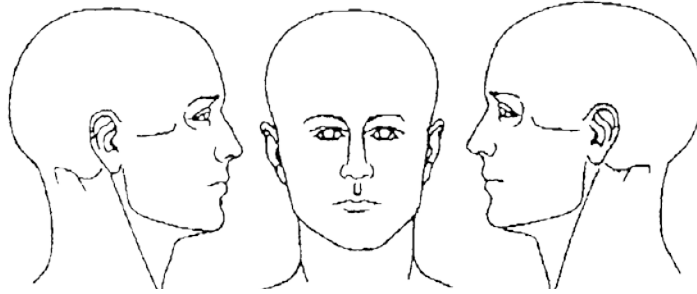
Past birth control methods:	Current birth control method:
-----------------------------	-------------------------------

**Check if you have or had any of these:**

<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Addiction ( to_____ )</p> <p><input type="checkbox"/> <input type="checkbox"/> AIDS / HIV</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood clots</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer / tumor</p> <p><input type="checkbox"/> <input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> <input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> <input type="checkbox"/> Chronic fatigue syndrome</p> <p><input type="checkbox"/> <input type="checkbox"/> Colon / bowel disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional / mental illness</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p>	<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Fibromyalgia</p> <p><input type="checkbox"/> <input type="checkbox"/> Gall bladder disease / stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> <input type="checkbox"/> Gum disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis or jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> <input type="checkbox"/> High / Low BP (circle one)</p> <p><input type="checkbox"/> <input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney or bladder infection</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Lupus</p> <p><input type="checkbox"/> <input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> <input type="checkbox"/> Measles, Mumps or Rubella</p> <p><input type="checkbox"/> <input type="checkbox"/> Mononucleosis</p>	<p><b>Past    Now</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoporosis / osteopenia</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Parkinson's</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Polio</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic or Scarlet fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Shingles</p> <p><input type="checkbox"/> <input type="checkbox"/> Spinal meningitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid trouble or goiter</p> <p><input type="checkbox"/> <input type="checkbox"/> Ulcer</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> <input type="checkbox"/> Venereal disease</p> <p>Other:</p>
--	--	---

Surgeries, hospitalizations & dates:	Accidents, injuries & dates:	Medications, reasons & dosages:
		<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

**Please Indicate Areas of Pain or Discomfort:**



- Back pain or trouble -----1 2 3 4 5
- Muscle pain, spasm, cramping - 1 2 3 4 5
- Muscle weakness ----- 1 2 3 4 5
- Restless or nervous legs ----- 1 2 3 4 5

- Spinal disc problems -----1 2 3 4 5
- Stiff or painful neck -----1 2 3 4 5
- Swelling ----- 1 2 3 4 5
- Tendonitis/Arthritis (where: \_\_\_\_\_ )

**Please describe your pain/discomfort:**

---



---



---



---



---

**By signing, I attest that all information I have provided on this Health History is true, accurate and complete. I also understand that if I wish to change the dosages of my medications, Dr. Bhatti recommends that this happen gradually and with consent of my primary medical doctor.**

**Sign:**

**Date:**

## Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW CAREFULLY.**

### Uses and Disclosures

**Treatment:** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment:** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health Care Operations:** Your health information may be used as necessary to support the day-to-day activities and management of Awaken LLC. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law Enforcement:** Your health information may be disclosed to law enforcement agencies to support government audits and inspections to facilitate law-enforcement investigations and to comply with government mandated reporting.

**Public Health Reporting:** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that had occurred before you notified us of your decision to revoke your authorization.

**Appointment Reminders:** Your contact information will be used by our staff to send you appointment reminders.

### Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

### Awaken LLC Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

### Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

### Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Office Director or your physician directly. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

### Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

[awakenorlando@gmail.com](mailto:awakenorlando@gmail.com)

# Saima Bhatti AP, DOM

2909 N. Orange Ave. Orlando, FL 32804 | (xxx)xxx-xxxx

## Consent to Treatment

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named above and/or other licensed acupuncturists who may now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named above, including those working at the clinic or office listed above or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxabustion, cupping, electrical stimulation, tui-na (Oriental massage), oriental herbal medicine, homeopathy, and nutritional counseling. I understand that the herbs may need to be prepared and consumed according to the instructions provided orally and in writing. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally a safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. Burns and/or scarring are a potential risk of moxabustion and cupping. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that the results are not guaranteed.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

(Date)

PATIENT SIGNATURE:

(or patient guardian-) \_\_\_\_\_

(-indicate relationship-)

(Date)

OFFICE SIGNATURE: \_\_\_\_\_

Dr. Saima Bhatti AP, DOM  
FINANCIAL POLICY AND  
AUTHORIZATION TO BILL  
INSURANCE

---

**There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time you choose to change your billing option, you are required to let us know immediately and sign a new form.**

\_\_\_\_\_ **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 out for today's visit, and every visit hereafter. Awaken LLC will submit my claim for me to my insurance company. Although Awaken LLC 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 unpaid for over **90 days**, the balance can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to Saima Bhatti. I also authorize the doctor 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.

\_\_\_\_\_ **Private Pay**

Private pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to the published rate if you pay at the time of service.**

**Payment Methods Accepted:** Cash, Check, Visa, Mastercard, Discover and Debit Cards are accepted.

**Returned Checks:** Each returned check will incur a fee of \$30.

**Cancellations or Missed Appointments:** Appointments may be canceled or rescheduled online, or by calling (407) 244-1221 **at least 24 hours in advance.** Appointments that are canceled or rescheduled within 24 hours of the start time will be charged for **50%** of your appointment rate; if you miss your appointment and **we do not hear from you**, you will be charged the **full payment** of your scheduled services.

---

Paying in full at the time of service frees our office from the administrative costs that would be required in medical billing. We have adjusted our "usual and customary" fees. Your superbill/receipt form will show exam and treatment procedures that occurred during your visit. Depending on the visit and the nature of your treatment, certain procedure codes and/or exam codes may be modify payment and you will only be responsible for certain other fees: Your out-of- pocket fees will be as follows:

New Patient: \$95

Follow-up: \$85

Initial Consult & B12: \$65

Herbs, Supplements & Homeopathic: varies

Vitamin B12/Homeopathic injection : \$30

Cupping/Food & Herbal Consult: \$45

---

**I have read and agree to the above Financial Policy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date