Patient Registration Form

Dear Client: This information is considered confidential. Because we care, this information will help us determine if the treatment offered here will help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you.
PLEASE PRINT.

PERSONAL: Today's Date:_____

Name:_____ Sex:____ Marital Status:_____ Date of Birth:_____
(First Middle Last) M/ F M S D W

Address:_____ Zip Code:_____
Street City State

Contact Phone /Cell Number: (____)_____ Home # : _____

Contact email: _____ This is only for office updates & health notices

Employer's Name: _____ Employer's Address:_____

Business Phone#:(____)_____ Your Occupation:_____
(Student, retired, homemaker, etc)

Who referred you to our office? _____ May we contact this person to say thank you? Yes No

Please describe the principal health problems for which you came to this office _____
_____

Duration of this condition: _____What are your treatment goals? _____

FEMALES ONLY: When was your last period? _____ Are your pregnant? Yes No

PERSONAL IDENTIFICATION: Drivers License #:_____ State: _____

Name, Address & Relationship of nearest Relative: _____
_____

HEALIH INSURANCE Name of Medical Insurance: _____

Billing Address:_____

Phone Number: (_____)_____ Social Security # : _____
Insured Name on Policy & Policy #: _____

Spouse's Name:_____ Spouse's Social Security #: _____

Spouse's Employer Address(Address, City, State, Zip)_____

Financial Agreement:
ASSIGNMENT AND RELEASE:
I authorize payment of benefits be made directly to this healthcare provider and I understand that the service(s) listed above may or may not be covered by my insurance, and that I will be responsible for any and all charges related to the service(s) shown.
DATE: _____ **NAME**: _____

Client Signature: _____

Cancellation Policy
Out of consideration for other patients, our cancellation policy requires a minimum 48 hours notice. Not providing 48 hours notice, not showing up, or being more than 30 minutes late without informing us obligates us to charge your account a standard fee for the cost of the treatment missed. Compliance allows us to better serve you and other patients. Thank you for your understanding.
DATE: _____ **NAME**: _____

Client Signature: _____

Present Complaint:

What is your #1 chief complaint? _____

When did this condition begin? _____

What treatment have you already received? _____

What exacerbates and what alleviates the condition? _____

MEDICATION:
I am currently taking the following kinds of medications and doses, and have noted what the medications are for and what effects they have on me: (If I am on no medication I will write "none" across all five lines below.)

1. _____

2. _____

3. _____

4. _____

5. _____

Initial here: _____

My most prominent symptoms are:
(Please rate the intensity of the symptom on a scale of 1 to 10, where 10 is the worst possible)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

Initial here: _____

Informed Consent

1. While the overall record of the use of ILF neurofeedback is quite successful, there can be no guarantee of success in your particular instance. Before you give your consent to be treated, please read the following and ask as many questions as are necessary for you to understand this process.

2. ILF neurofeedback is not a medical treatment and is no substitute for effective standard medical treatment. If you need medical treatment, you are urged to seek it. And it is important to report any odd or uncomfortable sensations or experiences to your ILF neurofeedback clinician and to your physician. Those whose medical status is unstable should consult with their physician about becoming more medically stable before undertaking this treatment.

3. If you are taking medication, it will be necessary to stay in close contact with your physician. It has been our observation that the need for these medications often decreases, and people may start having side effects. The types of medication include those for sugar problems (diabetes), thyroid problems, migraines and other headaches, seizures, movement problems, spasticity and low or high blood pressure and various emotional, thinking, or perceptual problems.

4. While the long-term effects of using electrical field feedback as we use it is unknown, for reference, a cellular telephone generates a signal at least millions of times the power of the, ILF neurofeedback, feedback signal. The intensity of our field is less than a trillionth of a watt and is on for a few seconds during each session. A background signal approximately a thousand times less than the feedback signal is also present as soon as the EEG begins to read the brainwaves. No instances of problems with the emissions from the feedback have ever been recorded.

CONFIDENTIALITY:
Your treatment is fully confidential in accordance with HIPPA regulations.

PERMISSION FOR TREATMENT:
I, a prospective patient, give my full permission to Tueykay Jew, supervisor, or other staff of her office to use any data collected during the preparation and participation in the ILF neurofeedback sessions as long as my confidentiality remains intact. Initial:_____

I acknowledge that I have been given an opportunity to ask questions regarding this new treatment and that these questions have been answered to my satisfaction. I acknowledge that I have read and understand the above information, and agree to participate in this treatment. My consent to participate in this treatment is given voluntarily and without coercion. I understand that I may discontinue treatment at any time, and that I may refuse to consent without penalty. Initial:_____

Michèle Lamarche or other staff of his office has my permission to contact my physician or health care provider to both inform him/her of the circumstances and outcomes of my treatment, and request pertinent medical information about me. Initial:_____

I hereby give my consent to Tueykay Jew, L.Ac., or the staff of her office, to record both benefits and unpleasant effects from ILF neurofeedback. Initial:_____
I have read and understood the contents of this document, and consent to receive this treatment. Initial:_____

_____
Signature of Patient or Representative

Date: _____ Name:_____ Age:_____

Diagnosis:_____

Notice of Privacy Practices For Patients (HIPPA)

The privacy of your medical information is important to us and we are committed to protecting it. This notice describes how information about you may be used and disclosed, as well as how you can get access to this information. Please read this information carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations. These include emergency care, quality assurance activities, payment, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a written request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We have the right to make changes to our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Contact Person:
Tueykay Jew, L.Ac.
2801 Ocean Park Blvd # 222
Santa Monica, CA 90405.

I, _____ Hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____ Date: _____