

Lindsay Chimileski ND LAc

Matthew Robsinon ND

Hawthorn Holistic Health



NEW PATIENT INTAKE FORM

Name	Birthday
Address	Gender & Pronouns
Phone	Are we authorized to leave a message? Yes or No
Email	We use email for patient portal and appointment reminders. Circle Yes to sign up for our newsletter for upcoming events, hours & seasonal health info (max 15 emails a year)
Primary Care Physician	In Connecticut, NDs are specialist, not PCP.
Emergency Contact, Relationship & Phone Number	
How did you hear about us	
Medical History	
List ALL Known Allergies (medications, foods, insects, environmental, chemicals). Rate mild, moderate, or severe	
Any history of anaphylaxis?	
History of Hospitalizations, Surgeries, Major Accidents or Traumas:	
Any Pre-existing Medical Conditions:	
Are you pregnant or trying to conceive:	
FAMILY HEALTH HISTORY All known major illnesses, diseases, cancers, addictions, age, and cause of death, if deceased	
Mother & her parents	
Father & his parents	
Sibling(s)	
Children	
Are you interested in any specific therapy? Circle Options below or write in <i>Acupuncture Nutritional Counseling Physical Medicine Alternative Lab Testing Homeopathy "Whatever the doctor thinks is best"</i>	

What brings you in today?

Chief Concerns:

Health Goals:

Medications and Supplements

List all medicines and supplements you are currently taking. Include how long you have been taking it and dose or strength.

Lifestyle & Nutrition Describe in your own words or Rate on a scale 1-10(10 being the highest)

Occupation

Physical Activity level

Restrictions to Physical Activity

Relationship status & living situation

What do you do for fun

Connection to community and support systems

Are you fast or slow paced? Uptight or easy going?

Do you use any of the following? If so, how many times: daily, 1x/week, 1x/month, 1x/year

Tobacco

Caffeine (Coffee, Tea, Soda, Energy drinks, Preworkout etc)

Alcohol, if so what kind

Recreational drugs

Cannabis

Psychedelics

Kratom, Opiates, Pain Medication

Other daily substances

Describe your diet (circle any that apply):

Vegan Vegetarian Pescatarian Gluten Free Halal Dairy Free Low Fat Kosher Standard American

Any specific foods you avoid?

Quality of Life Rate on a scale from 1 to 10, 10 being the best, or describe in your own words	
Sleep Quality	Do you Dream?
Stress Level	Where and how do you feel it in your body?
Energy levels	What time is energy the highest? What time is energy the lowest?
Appetite	Libido & Sex Drive
Baseline Daily Mood:	

Detailed Pain Information	
Rate the pain on a scale from 1-10 (10 being the worst):	<i>RIGHT SIDE or LEFT SIDE</i>
Where do you have body pain?	
How long have you had the pain? When was the initial Injury?	
Any pattern and timing you have noticed? Write in or circle <i>When I wake up In bed at Night With Movement Stress induced Weather Changes Hormonally Changes</i> <i>Day after use/activity Sitting Standing Seasonal changes</i>	
How would you describe the pain?	<i>Ache Burning Stabbing Stiffness Electric Unbearable Other:</i>
Specific triggers?	
Other symptoms & details you experience with it?	
What makes it better?	What makes it worse?
Headaches: How often?	How long has this been a problem? Rate 1-10, 10 being the worst
Location?	<i>RIGHT SIDE or LEFT SIDE</i>
<i>Sinus Behind eyes Top of head Temples Whole head Band around head Base of skull/ top of neck</i>	
Any pattern and timing you have noticed?	
<i>When I wake up In bed at Night With Movement Stress induced Weather changes Seasonal changes</i> <i>Hormonally Changes Day after use/activity Sitting Standing Other:</i>	
How would you describe the pain?	<i>Ache Burning Stabbing Stiffness Electric Unbearable Other:</i>
What makes it better?	What makes it worse?

Please complete the checklist, marking off the symptoms you experience now or have been a significant part of your health history in the past. Elaborate when necessary.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anxiety, Worry, Nervous | <input type="checkbox"/> Runny or Watery Eyes | <input type="checkbox"/> Spitting up mucus or blood | <input type="checkbox"/> Muscle Pain or tightness |
| <input type="checkbox"/> Overthinking | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Joint Pain or stiffness |
| <input type="checkbox"/> Tired, Weak, Low Energy | <input type="checkbox"/> Night Blindness or Halos | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Bone Pains |
| <input type="checkbox"/> Depression, Melancholy, | <input type="checkbox"/> Red or Puffy Eyes | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Tremors, twitches |
| <input type="checkbox"/> Moodiness | <input type="checkbox"/> Ear aches & infections | <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of strength |
| <input type="checkbox"/> Anger, "Road rage", Irritability | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Apathy, Hopelessness | <input type="checkbox"/> Diminished hearing | <input type="checkbox"/> Nausea, Vomiting | <input type="checkbox"/> Leg pains, Leg cramps |
| <input type="checkbox"/> Self harm | <input type="checkbox"/> Wax buildup | <input type="checkbox"/> Bad breath, thick tongue coat | <input type="checkbox"/> Hands or feet turn white or blue |
| <input type="checkbox"/> Bottled up emotions | <input type="checkbox"/> Hair Loss, breaking, thinning | <input type="checkbox"/> Excessive appetite, binge | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Overstimulation | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Heart burn, reflux | <input type="checkbox"/> Tendency to Anemia |
| <input type="checkbox"/> Manic, Impulsive | <input type="checkbox"/> Acne, Pimp les, Cysts | <input type="checkbox"/> Digestive Pain after eating | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Rashes | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Grief | <input type="checkbox"/> Ulcers or sores | <input type="checkbox"/> Digestive Pain, empty stomach | <input type="checkbox"/> Shortness of breath walking upstairs |
| <input type="checkbox"/> Worry | <input type="checkbox"/> Dry, Rough, Cracking, Scaling | <input type="checkbox"/> Difficulty digesting fats | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Fear | <input type="checkbox"/> Ulcers or sores | <input type="checkbox"/> Stool dark colored | <input type="checkbox"/> Nighttime urination |
| <input type="checkbox"/> Insomnia or Waking frequently | <input type="checkbox"/> Brown spots or bronzing | <input type="checkbox"/> Light colored stool | <input type="checkbox"/> Pain with urination |
| <input type="checkbox"/> Vivid Dreaming or Nightmares | <input type="checkbox"/> Facial rash or rosacea | <input type="checkbox"/> Food or Blood in stool | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Flushing, Hives | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cloudy urine |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Moles, Warts, Skintags, | <input type="checkbox"/> Incomplete elimination | <input type="checkbox"/> Foamy urine |
| <input type="checkbox"/> Inability to sweat | <input type="checkbox"/> Slow healing cuts | <input type="checkbox"/> Loose stool, diarrhea | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Excessive sweating, | <input type="checkbox"/> Scaring, Keloid | <input type="checkbox"/> Foul odors | <input type="checkbox"/> Bladder or Kidney infection |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Runny Nose, Hay fever, Sinusitis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Cramping Pains | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Dizziness or loss of balance | <input type="checkbox"/> Dry or chapped lips | <input type="checkbox"/> Bloating | <input type="checkbox"/> Enlarged Prostate |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Sore throat or tonsillitis | <input type="checkbox"/> Belching, Gas | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Concussion or Head Trauma | <input type="checkbox"/> Clearing throat often | <input type="checkbox"/> Headache/Angry if meal skips | <input type="checkbox"/> High libido |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Red, Sore, Cracked tongue | <input type="checkbox"/> Palpitations, | <input type="checkbox"/> Pain with intercourse |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Cold sores, Herpes or Shingles | <input type="checkbox"/> Racing heart, Irregular | <input type="checkbox"/> Genital pain or discomfort |
| <input type="checkbox"/> Hands tingling, Feet tingling | <input type="checkbox"/> Diminished smell or taste | <input type="checkbox"/> Dizziness upon standing | <input type="checkbox"/> Difficulty completing intercourse |
| <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Many Cavities or dental work | <input type="checkbox"/> Altitude sickness | |
| <input type="checkbox"/> Glasses or Contacts | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Chest Tightness | |
| <input type="checkbox"/> Blurred or Poor Vision | <input type="checkbox"/> Horse or raspy voice | <input type="checkbox"/> Swollen feet or ankles | |
| <input type="checkbox"/> Dry, Itchy, Burning Eyes | | <input type="checkbox"/> Cold hands or feet | |



CONSENT TO TREAT:

Hawthorn Holistic Health, LLC is pleased to offer you a variety of in-office procedures and medical therapies.

Please sign below to indicate you understand and consent to following treatments:

Naturopathic Medicine, Nutritional, Vitamin, Supplement & Lifestyle Counseling

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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.

Patient or Guardian Print Name: _____ **Date:** _____

Patient or Guardian Signature: _____ **Date:** _____

Physical Medicine, Acupuncture & Traditional Chinese Medicine

Acupuncture: insertion of sterile, one time use, solid needles to specific medically safe locations.

I hereby request and consent to the performance of Acupuncture and Traditional Chinese Medicine (TCM) procedures by Dr. Lindsay Chimileski, ND. I have had the opportunity to discuss and understand the nature and purpose of Acupuncture and TCM treatments with the acupuncturist named above and/or with other office or clinic personnel. I have been informed that Acupuncture is a safe method of treatment, but occasionally there may be some bruising, itching or tingling near the needling sites that can last a few days. I realize that although rare, there have been few instances fainting, infections, scarring, spontaneous abortion and pneumothorax.

➤ I understand it is imperative to tell the acupuncturist if I am PREGNANT or trying to get pregnant because although safe with pregnancy, specific rules and cautions must be used by the practitioners.

➤ I realize that Acupuncture and TCM is based on a different medical system than conventional doctors and visits to your primary care provider are still recommended. I wish to rely on the acupuncturist to exercise judgment based on his formal training to guide course of the treatment.

Cupping : using glass or plastic cups to create suction to remove stagnation and adhesions in the underlying tissue. This often leaves the appearance of bruising (ecchymosis) and/or local tenderness that can last 2-7 days.

Moxibustion: burning *Artemisia vulgaris*, or Mugwort, near or directly on the skin or acupuncture needle to promote circulation and warm the tissues. Rarely, this may cause first degree burning or skin blistering.

Gua Sha : using massage tools to dredge superficial soft tissue (fascia and muscles) and remove adhesions in the underlying tissue. This often leaves the appearance of bruising (ecchymosis) that can last 2-7 days.

Tui-Na Chinese Massage: using hands on soft tissue massage, active range of motion and acupressure to move qi and blood, remove stagnation and treat underlying disharmonies.

Physical Medicine & Hands-on therapies including massage, stretching, craniosacral, biocranial, myofascial release, Naturopathic Manipulation Therapy, hot/packs, contrast hydrotherapy, e-stim, ultrasound and joint mobilization.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. 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.

Patient or Guardian Print Name: _____ **Date:** _____

Patient or Guardian Signature: _____ **Date:** _____

ACKNOWLEDGEMENT 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 it carefully)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I consent to the use or disclosure of my protected health information by Hawthorn Holistic Health LLC (HHH), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of HHH. I understand that diagnosis or treatment of my by any of the physicians at HHH may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. HHH's *Notice of Privacy Practices* is also available in our waiting room.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing, except to the extent that action has already been taken in reliance thereon.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

Dr. Lindsay Chimileski
PATIENT FINANCIAL RESPONSIBILITY FORM

Welcome and thank you for choosing Hawthorn Holistic Health as one of your healthcare providers. Dr. Lindsay Chimileski does not participate with any insurance companies at this time. All payments for visits, supplements and services will be due on the day of service.

Out-of-Network Benefits Some patients may be able to get reimbursed for services or it may be applied to your deductible. Every insurance plan is different. It will be the responsibility of the patient to contact their insurance provider and clarify their out of network benefits, information needed and the process for timely submitting.

There is more work required in order for prepare the proper documents for you to submit, therefore patients must tell our team at the time of scheduling that they plan to submit their superbills. When submitting superbills, the codes and fees we have to use are different and the charges will be higher than the set cash rate. *Packages and memberships will not get reimbursed for out of network coverage.*

We do accept **Flex Spending and Health Savings Accounts for payment.** To find out if your insurance company will reimburse you for our services, contact them directly or speak with your plan administrator. Once you find out what you need in order to submit, we can work to provide that information for you. Some HSA or flexible spending accounts may cover acupuncture treatments or other services and visit types. It is possible that you will need a letter of medical necessity for it from your PCP. You must contact your insurance to verify. Supplement coverage will continue to be covered as is.

Membership contracts are billed on a monthly recurring basis. It is mandatory to have a credit card on file that does not expire for the duration of the contract. If it does expire, you will need to keep another card on file that the expiration date extends past. All memberships have a 2 month minimum, no exceptions. Membership fees will be automatically charged each month for the duration of the membership. The withdraw will occur based on the date of the initial purchase. For example with a 6 month contract, if purchased on the 18th, for the following 5 months it will be withdrawn on the 18th. Any failed payments will incur a \$25 charge. To cancel the membership after two months, there will be a \$50 fee. The office must be called 72 hours before the withdrawal to cancel for the remaining cycles.

Appointments do not roll over month to month and expire at the next renewal date. In the cases of serious injuries, illnesses and emergencies please contact our office biller Robin at 203-530-0203 to discuss options around putting the membership on pause or cancelling.

Packages must be used within 12 months of purchase. There is no autorenewal. Start date is based on the date of purchase, so it is best to purchase it the same day you plan to use the first one. Packages can be shared with family members whose billing accounts are linked only.

I hereby acknowledge that I am personally responsible for all fees, I understand that my account will be charged \$25.00 for any checks returned due to non-sufficient funds. I also agree that I am responsible for any collection and/or attorney fees.

Date: _____.

Name and Signature of Responsible Party:

Appointment Cancellation & Financial Policies

Please familiarize yourself with our cancellation policy and missed appointment fees.

When we schedule an appointment, we agree to show up for one another. Each visit is a commitment of the doctors' time. Late cancellations and missed appointments limit the accessibility of our doctors for other patients in need. In the event that you must cancel or change your appointment, please contact us, at (203) 553-7392, at least 2 business days in advance of the appointment. Cancellations that occur in less than 2 business days and no-shows will be charged a fee. These fees are not covered by insurance. For Monday appointments, please contact us by Friday at 12pm.

If you cancel with less than 48 hours notice, you will be responsible for a \$75 late cancellation fee. If you do not call or reschedule and do not show up for your appointment, you will be responsible for a \$95 no show fee.

In the event of multiple missed appointments, after two missed appointments (no call or same day cancellations) you will be required to keep a credit card on file and it will be charged the \$95 missed appointment fee on the day of any missed appointment in the future.

Individuals who have not shown for two consecutive appointments, will have their remaining appointments canceled and must call the office if they would like to reschedule. The missed appointment fees must be paid before the start of your next office visit.

I understand that my account will be charged \$25.00 for any failed payments or checks returned due to non-sufficient funds.

I hereby acknowledge that I am personally responsible for all fees. I agree to pay all applicable charges and to promptly pay any balance in full. I also agree that I am responsible for any collection and/or attorney fees.

Date: _____

Name and Signature of Responsible Party: