

Patient Information Form

Name: _____ Date of Birth: _____

Home Phone: _____ Wk: _____ Cell: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Marital Status: _____

Emergency Contact: _____ Relationship _____

Contact's Phone number: _____

Email Address: _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed Kathleen M Bynum, DO, PA's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority
(guardian, parent etc...)



Kathleen M. Bynum, D.O., P.A.

5323 Miller Ave.
Dallas, TX 75206
214.823.6762

Practice parameters:

This is a fee for service practice and payment is due at the time of service. There is a 24 hr cancellation policy otherwise you will be charged for the appointment time.

Kathleen M. Bynum, D.O. does not bill any insurance companies. She will provide you with a receipt so that you can file with your insurance carrier.

Kathleen M. Bynum, D.O. is practicing acupuncture as a specialty and is not acting as your primary care physician. She recommends that you have a primary care physician to provide your regular medical care, and provide a medical workup for your problem or disease. She does not provide emergency care, have 24 hour coverage, or provide call coverage. If you require emergency care, or urgent care, you need to see your primary care physician or go the emergency room.

I have read the above and understand these policies.

signature

date

print name



Kathleen M. Bynum, D.O.
Acupuncture
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ADVANCED BENEFICIARY NOTICE FOR MEDICARE PATIENTS

Medicare does not pay for acupuncture because it considers it to be experimental. This is to inform you that since it does not cover this service I will not file with Medicare and you are responsible in full for payment.

Medicare wants me to inform you that traditional forms of therapy exist for your condition and that you should consider these options.

I have read and understood the above.

signature

date

print name

Name:

Today's Date:

Health Questionnaire

Hospital Admissions, Surgeries, Trauma

Yr	Illness or Surgery	Yr	Illness or Surgery	Yr	Illness or Surgery

Medications and Supplements

Drug Allergies

Other Sensitivities

Check any diseases or problems you have

- | | | |
|--------------------------|-----------------|----------------------|
| Asthma | Thyroid disease | Raynaud's |
| COPD/Emphysema | Hypothyroid | Eye Disease |
| Frequent Infections | Hyperthyroid | Glaucoma |
| Hayfever/allergies | Neck Pain | Macular degeneration |
| Diabetes | Back Pain | Liver Disease |
| High Cholesterol | Extremity Pain | Hepatitis |
| Hypertension | Muscle Pain | Gallbladder problems |
| Heart disease | Other Pain | IBS |
| Neurological problem | Carpal Tunnel | Crohn's /colitis |
| Stroke | TMJ | Reflux |
| Seizures | Headaches | Anemia |
| Kidney disease/stones | Migraine | Erectile Dysfunction |
| Chronic Fatigue Syndrome | Tension | Cancer |
| Fibromyalgia | Arthritis | HIV |
| Lupus | Rheumatoid | Depression/anxiety |
| Multiple Sclerosis | Osteoarthritis | Sleep disorder |

Please list any others:
