

Yarrow Holistic Center
Sherry Daghighi, DAOM, L.Ac

Please PRINT clearly –All information must be completed

Patient Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Social Security # _____ - _____ Sex: F M Other

Home Address: _____
Street Apt# City State Zip code

Home Phone: (____) _____ Cell Phone: (____) _____

Marital Status: Single Married Other Email Address: _____

Employer: _____ Title: _____ Phone: (____) _____

Employer's Address: _____
Street Suite# City State Zip Code

Family Physician: _____ Phone: (____) _____

Spouse Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security # _____ Sex: F M

Phone Number: (____) _____

Referring Physician name and number:

This will constitute authorization for treatment by Sharareh Daghighi, L.Ac for my child/ward or me. In the event of default, patient responsible party agrees to pay all collections and attorney fees. I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by my insurance. A copy of this authorization shall be considered as valid as the original.

Signature: _____ **Date:** _____

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Medical Questioner

Please complete the following as accurately as possible

Name: _____ Date: _____

Present Illness:

What is your chief complaint?

When did this condition begin?

What treatments have you received already?

Medical History:

What surgeries have you had? When did you have them?

Do you have any known allergies (food or medications)?

What medications are you currently taking?

What supplements are you currently taking?

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Have any of your blood relatives had any of the following?

- | | |
|--|---|
| Stroke <input type="checkbox"/> | Bleeding disorders <input type="checkbox"/> |
| Heart Disease <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> |
| High BP <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | |

For Female patients please complete the following:

- | | |
|--|--|
| Age of your first period: _____ | Menstrual blood clots _____ |
| Pregnancy Dates: _____ | Excessive bleeding _____ |
| Date of last period? _____ | Breast pain with your period _____ |
| Length of your cycle? _____ | Vaginal discharge _____ |
| Color of Blood? _____ | Menopausal symptoms _____ |
| Menstrual cramps: <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Vaginal yeast infections _____ |
| Emotional changes with your period: <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |

Please complete the following as accurately as possible:

Indicate if you have any of the followings:

- | | | |
|--|--|---|
| Headache <input type="checkbox"/> | Emphysema <input type="checkbox"/> | Heart burn <input type="checkbox"/> |
| Dizziness <input type="checkbox"/> | Cough <input type="checkbox"/> | Constipation <input type="checkbox"/> |
| Fainting <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Diarrhea <input type="checkbox"/> |
| Epilepsy & convulsion <input type="checkbox"/> | Frequent colds <input type="checkbox"/> | Irritable bowel Syndrome <input type="checkbox"/> |
| Stroke <input type="checkbox"/> | High blood pressure <input type="checkbox"/> | Peptic ulcer <input type="checkbox"/> |
| Loss of memory <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Jaundice <input type="checkbox"/> |
| Loss of any five senses <input type="checkbox"/> | Heart Disorder <input type="checkbox"/> | Fatty liver <input type="checkbox"/> |
| Thyroid problem <input type="checkbox"/> | Cardiac pacemaker <input type="checkbox"/> | Pancreatitis <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Palpitation <input type="checkbox"/> | Gallstone <input type="checkbox"/> |
| Pneumonia <input type="checkbox"/> | Indigestion/gas <input type="checkbox"/> | Diabetes <input type="checkbox"/> |

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Hepatitis

Hernia

Kidney stones

Frequent urination

Urinary tract infection

Impotence

Infertility

Premature ejaculation

Prostate problem

Sexually transmitted disease

Indicate _____

Sores that don't heal

Cancer

What kind of Cancer _____

Insomnia

Skin disease

Arthritis

Osteoarthritis

Osteoporosis

Lupus

Rheumatic Arthritis

Herniated disk

Muscle spasm

Numbness & tingling

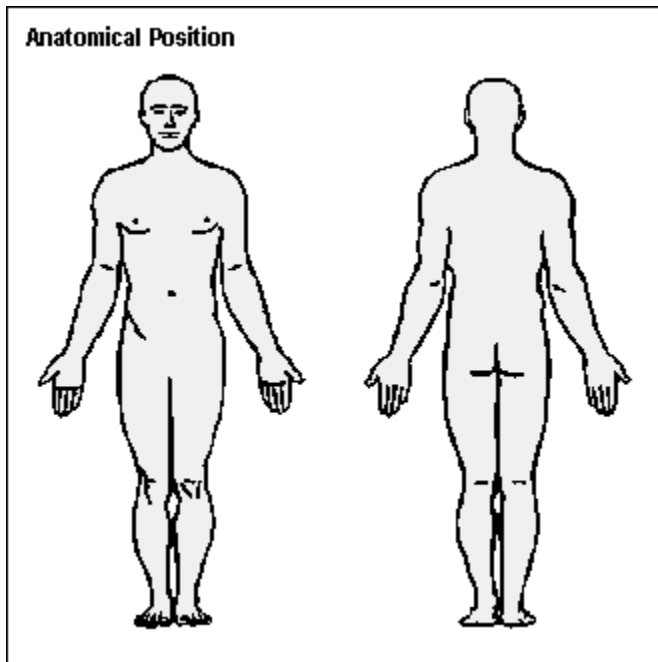
Fibromyalgia

Chronic fatigue syndrome

Anemia

Bleeding disorders

Mark X where you feel pain or discomfort



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**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

NAME _____

BIRTHDATE _____

I understand that as part of my healthcare, or my legal dependent's healthcare, this organization originates and maintains health records describing health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning care and treatment.
- A means of communication among the many healthcare professionals who contribute to care.
- A source of information for applying diagnostic and medical information to a bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of health information for directory purposes.
- To request restrictions as to how this health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

I request the following restrictions to the use of disclosure of my health information:

Patient/Legal Representative signature: _____

Witness signature: _____

Date: _____

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MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

Thank you for trusting your medical care to Yarrow Holistic Center. We strive to render excellent medical care to you, your family and all of our patients. In order to be consistent with this philosophy, Yarrow Holistic Center uses an appointment system that sets aside ample time for a patient dependent on the patient's current needs. If you do not show up for your appointment, or notify us of your inability to keep your appointment by phone at least 48 hours in advance, the time that has been allotted for your visit cannot be used to treat another patient and is time lost to our office. With that in mind and in order to keep costs as low as possible, a Medical Appointment Cancellation Policy has been put into place.

Our policy is as follows:

1. We request that you please give our office a 48-hour notice in the event that you need to reschedule your appointment. This will make the appointment time available to someone else. Our scheduling number is 765-715-0032.
2. If you miss an appointment and do not contact us with at least 48 hours prior notice we will consider this to be a missed appointment and a \$60.00 fee will be assessed to you.
3. If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shortened in length.

If you have any questions regarding this policy, please contact Sherry Daghighi at the above address or phone number and he will be glad to clarify any questions you may have. We thank you for your patronage.

I have read and understand the Medical Appointment Cancellation Policy and agree to be bound by its terms.

Signature (Parent / Legal Guardian) Relationship to Patient

Printed Name

Date

Yarrow Holistic Center
Sherry Daghighi, DAOM, L.Ac

By signing this authorization, I authorize you to use and/or disclose certain protected health information (PHI) about me to:

Yarrow Holistic Center
Sharareh (Sherry) Daghighi, DAOM, L.Ac
<https://yarrowholisticcenter.com/>

Dear Dr, _____

I authorize you to release a copy of the medical records of:

Patient name: _____
Date of birth: _____
Social Security #: _____
Covering the period of _____ to _____

Please email the medical records to the email address: <https://yarrowholisticcenter.com/>

The specific information requested is the office visits, labs, x-ray, surgeries, op reports, etc. The purpose(s) is/are provided so that I can make informed decision whether to allow release of the information.

The authorization will expire on _____

I release you from all legal responsibility or liability that may arise from this authorization.

Please release my medical records, including:

- All of my medical records (excluding HIV testing)
- All of my medical records (Including HIV testing)
- Please exclude the followings: _____

Patient's signature: _____ Date: _____

Patient's name: _____

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