HEALTH DISCOVERY ACUPUNCTURE

**Our Philosophy**
First, do no harm
Enhance the healing power of nature
Address causes of disease
Heal the whole person
Teach principles of healthy living
Promote prevention
Support wellness

## General Information

Name:_____Date:_____/_____/_____

Address:_____City:_____State_____Zip:_____

Cell Phone:_____Home Phone:_____Work Phone:_____

Date of Birth:_____/_____/_____Age:_____Email:_____

Gender: □ Male □ Female Height:_____'_____" Weight:_____lbs.

Marital Status: □ Married □ Partnered □ Single □ Separated □ Divorced □ Widowed

Occupation:_____Employer:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Cell Phone:_____Home Phone:_____

How did you learn about our practice? □ Family or Friend □ Health Professional □ Event

□ Other:_____

Have you ever been treated by Acupuncture or Oriental Medicine before? □ Yes □ No

Was it a positive experience? □ Yes □ No

## Insurance Information

Insurance Network:_____Member ID #:_____

Group #:_____Payer ID #:_____

## Major Health Concerns

Acupuncture and Oriental Medicine support your body physically, mentally, and emotionally.

What health concerns brought you in today?

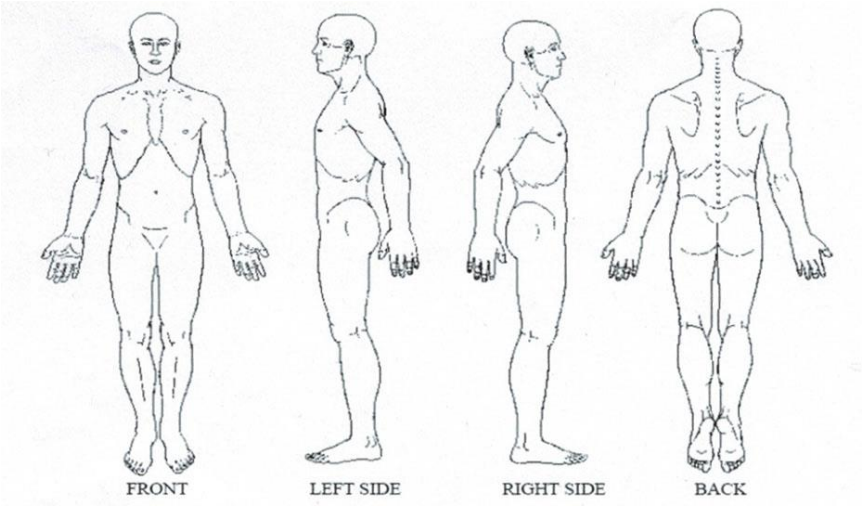
_____

_____

_____

If you are experiencing pain, please indicate the areas of your body where it is occurring using the following code:

| Code Legend |
|---|
| O - Dull or Achy |
| X - Sharp or Stabbing |
| N - Numbness |
| T - Throbbing |
| ↖ - Radiating |




**Chief Concern:**

_____

On a scale of 1 to 10 how severe is the pain?_____

How often do you notice the symptom? ____Constant ____Daily ____x a Week ____x a Months ____x a Year

**Secondary Concern:** _____

On a scale of 1 to 10 how severe is the pain?_____

How often do you notice the symptom? ____Constant ____Daily ____x a Week ____x a Months ____x a Year

If you are here for a holistic approach to disease prevention, please describe some of you systemic medical conditions or concerns.

_____

_____

Have you ever been diagnosed with:

□ High blood pressure □ Heart disease □ Stroke

□ Diabetes □ Seizures □ Asthma

□ Autoimmune disorder, please list type:_____

□ Cancer, please list type:_____

□ Allergies, please list type:_____

□ Major surgeries, please list types:_____

□ Major traumas or illnesses, please list types:_____

□ Car Accidents, please list your number of car accidents and how old you were at the time:_____

_____

## LIFESTYLE

**Alcohol** □ never □ 1-2 drinks a month □ 1-2 drinks a week □ 5-6 drinks a week □ daily
**Caffeine** □ never □ 1-2 drinks a month □ 5-6 drinks a week □ 1 drink a day □ multiple drinks a day
**Tobacco** □ never □ 1-2 times a month □ 1-2 times a week □ half a pack a day □ a pack a day
**Marijuana** □ never □ medicinal □ recreational □ other _____

## NUTRITION

Do you have a specific dietary restrictions or nutritional programs you follow? _____

_____

## CURRENT MEDICATIONS

Please list any medications and supplements you are currently taking (please use the back side if more space is needed):

| Medication/Supplement | Reason/Physician | Date began | Date ended | Dose | Help? Yes/No |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Family Medical History (stroke, heart disease, high blood pressure, cancer, skin disease, mental disorders, seizures, asthma, substance abuse, allergies, diabetes, etc.). Please indicate father, mother, siblings and grandparents _____

_____

**Check the conditions below that apply to you within the past 5 years.**

### Kidney & Bladder Meridian/Organ Network

- □ Adrenal weakness
- □ Back/hip/knee pain
- □ Bladder infec./control
- □ Brittle bones
- □ Cold hands/feet
- □ Dark/puffy around eyes
- □ Depression/fear
- □ Edema/water retention
- □ Hot flashes
- □ Impotence/libido
- □ Infertility/sterility
- □ Lethargy/fatigue
- □ Loss/thinning hair
- □ Night sweats
- □ Poor memory
- □ Premature gray
- □ Sciatica/back pain
- □ Sore throat in a.m.
- □ Tight hamstrings
- □ Tinnitus
- □ Urine problems
- □ Other_____

### Spleen & Stomach Meridian/Organ Network

- □ Abdominal pain
- □ Aching/heavy limbs
- □ Anemia
- □ Appetite/digestive prob.
- □ Belching
- □ Bruise easily
- □ Colic/indigestion
- □ Difficulty focusing
- □ Distention/bloating
- □ Headaches
- □ Heaviness at head
- □ Hemorrhoids
- □ Hiccups
- □ Irritable bowel
- □ Lethargy/fatigue
- □ Loose stools
- □ Muscle weakness
- □ Nausea/vomiting
- □ Poor memory
- □ Prolapse
- □ Worry/over-thinking
- □ Other_____

### Heart and Small Intestine Meridian/Organ Network

- ☐ Abdominal pain
- ☐ Anemia
- ☐ Anxiety/dread
- ☐ Digestive troubles
- ☐ Difficulty falling asleep
- ☐ Dream/disturbed sleep
- ☐ Elbow/shoulder pain
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hot flashes
- ☐ Hot/painful joints
- ☐ Lack of joy/humor
- ☐ Mouth sores
- ☐ Neck pain
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Restlessness
- ☐ Tongue/speech
- ☐ Upper back pain
- ☐ Urine problems
- ☐ Waking frequently
- ☐ Wrist pain
- ☐ Other_____

### Liver & Gallbladder Meridian/Organ Network

- □ Anger/irritability
- □ Breast tenderness
- □ Brittle/coarse nails/hair
- □ Bruising
- □ Depression
- □ Distention/bloating
- □ Eye/vision problems
- □ Flatulence
- □ Headaches
- □ Hemorrhoids
- □ Indigestion
- □ Irritable bowel
- □ IT Band tightness
- □ Lack of flexibility
- □ Menstrual irreg.
- □ Migraines
- □ Nausea/vomiting
- □ PMS
- □ Stiff neck/shoulders
- □ Tension/cramps
- □ Tinnitus
- □ Other_____

### Lung & Liver Intestine Meridian/Organ Network

- □ Allergies
- □ Arms/wrist/elbow pain
- □ Asthma/bronchitis
- □ Constipation
- □ Coughing/sneeze/phlegm
- □ Eczema/ psoriasis/rash
- □ Flatulence
- □ Frequent colds
- □ Frontal/sinus HA
- □ Grief/sadness
- □ Lethargy/fatigue
- □ Loose stools
- □ Mucus
- □ Nasal problems
- □ Shoulder pain
- □ Sinusitis
- □ Smell problems
- □ Stiff joints/ neck
- □ Sweating prob.
- □ Weak voice
- □ Wheezing/ SOB
- □ Other_____

### Female Reproductive System

Age of first menses_____
How long is your cycle from period to period?____days
How long does your period last?_____days
What color is your menses? (check all that apply)
□ Bright red □ Pale red □ Brown red □ Purple red
□ Mid-cycle bleeding □ Blood clots in menses
□ Cramps □ Low back pain
□ Breast tenderness □ PMS/Menstrual headaches
Number of pregnancies _____
Live births_____ Abortions_____ Miscarriages_____

## ACUPUNCTURE INFORMED CONSENT TO TREAT

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

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. 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 a generally safe method of treatment, but that it may have some side effects including dizziness, fainting, bruising, numbness or tingling near the needling sites that may last for a few days. Burns and/or scarring are a potential risk of moxibustion and cupping or when treatment involves the use of heat lamps. 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.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements that have been recommended, (which are from plant, animal and mineral sources), are traditionally considered safe in the practice of Chinese 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 the 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 results are not guaranteed.

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.

**X** _____ **Date** _____

**Patient or Guardian Signature**

## PATIENT RESPONSIBILITY
### (Please initial to the left of each paragraph)

_____ I understand that acupuncture practitioners do not diagnose illness, disease, other physical or mental disorders and do not prescribe medical treatment. Therefore it is my responsibility to obtain required prescription and or referrals for treatment that will be billed to any insurance entity. In addition, I have stated any known medical conditions and it is also my responsibility to inform my acupuncturist of any changes in my health.

## APPOINTMENT CANCELLATION AGREEMENT

_____ I understand that twenty-four (24) hour notice is not only appreciated, but also required when canceling an appointment. I also understand I will be asked to contribute a $40 donation to **YMCA Angeline's Center** for Homeless Women for missed appointments that I do not cancel before the 24 hour limitation, and agree to pay for such.

## PATIENT FINANCIAL RESPONSIBILITY

Thank you for choosing Health Discovery Acupuncture (HDA) for your care. We are honored to participate in your health care and look forward to establishing a lasting relationship as your health care provider. As part of this professional relationship, it is important to us to provide you with the details of our financial policy. Please do not hesitate to contact us if you have any questions or concerns. We ask that all patients read and sign our Financial Policy prior to the initial treatment.

1) I understand and agree that health and accident policies are a contract between my insurance company and myself. I also understand that HDA will not be calling my insurance company to verify my benefits, and I acknowledge that it is my responsibility to be familiar with and track the specifics of my insurance benefits (including, but not limited to, my deductible, co-pay, co-insurance, visit limit, and service year). If my insurance provider refuses payment, my services are not billable to insurance, or my deductible has not been met, I am directly and fully responsible to HDA for all bills submitted by them for services rendered to me.

2) I authorize payment directly to my provider and their affiliates for services rendered to me. I understand that co-payments (and any herbal/supplement charges) are due at time of service. I also understand that once HDA has collected payment from my insurance, I will receive an itemized invoice from HDA with an unpaid balance. There will be a statement surcharge fee for any balances due past 30 days. I understand that billed charges to me which go unpaid for an extended period will be sent to a third party collections company after 5 months of no received payment.

3) I understand that I am responsible to provide Health Discovery Acupuncture with the most correct and updated information about my insurance and I will be responsible for any charges incurred if the information provided is not correct or updated.

By signing below, I, _____, agree to accept FULL FINANCIAL RESPONSIBILITY as a patient who is receiving services or as the parent/guardian for the patient. I authorize payment of benefits to Health Discovery Acupuncture. My signature verifies that I have read the above, and understand my responsibilities, and had the opportunity to ask and have questions answered, and agree to the terms listed above.

**X** _____

**Signature of Patient or Legal Representative** **Date**

Updated 1/12/2017

# NOTICE OF PRIVACY PRACTICE

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. HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

**MY PLEDGE REGARDING YOUR MEDICAL INFORMATION**

I respect my legal obligation to keep health information that identifies you private. As obligated by law, I have prepared this explanation of how I am required to maintain the privacy of your health information and how I may use and disclose your health information. I do not use your health information in my office or disclose it outside of my office without your written permission. In some limited situation, the law requires me to disclose your health information without either a written or verbal consent.

**USE AND DISCLOSURE WITH CONSENT INFORMATION**

I will ask you to sign a consent form allowing me to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. I am not allowed to refuse to treat you if you do not sign the consent form.

I am permitted to use and disclose your healthcare records for the purpose of treatment and payment.

- Treatment means providing coordination, or managing healthcare related services by one or more healthcare providers. For example, I may need to share information with other providers or specialists involved in your care.
- Payment means activities as obtaining reimbursement for services, verifying coverage, billing or collection activities and utilization review.

Unless you request otherwise, I may use or disclose health information to a family member or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, I may use your confidential information to remind you of your appointments by leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and I am required to honor and abide by that written request, except to the extent that I have already taken actions relying on your authorization.

**USE AND DISCLOSURE WITHOUT CONSENT**

In some limited situations, the law requires me to use and disclose your health information without your permission. These examples may never come up at my office at all, but such disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose.
- For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
- Disclosure to government authorities about victims of suspected abuse, neglect or domestic violence.
- Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of healthcare laws.
- Disclosures in response to subpoenas or orders of the court.
- Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime at our office.
- Disclosure related to worker's compensation programs.

**YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you. I am, however, not required to agree to a requested restriction. If I do agree to a restriction, I must abide by it unless you agree in writing to remove it.
- The right to ask me to communicate to you in a confidential way, such as by phoning you at work rather than at home or by mailing health information to a different address. Please provide a written request.
- The right to ask to see or to get photocopies of your health information. You may have to pay for photocopies in advance. I do charge a fee to release your records to an outside source other than a healthcare provider (examples are lawyer, healthcare research firm, etc). Please complete my written records request for billing or medical record release.
- The right to receive an accounting of disclosures of protected health information.
- The right to amend your protected health information.
- The right to obtain a paper copy of this notice from me upon request.

I am required to abide by the terms of Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that I maintain. I will post and you may request a written copy of the revised Notice of Privacy Practices from this office.
You have the right to file a formal, written complaint with me, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel that your privacy rights have been violated. I will not retaliate against you for filing a complaint. This notice has been issued and considered effective date signed. This copy shall be retained by the department for a minimum of six (6) years.

**X** _____

**Signature of Patient or Legal Representative** **Date**

HEALTH DISCOVERY
ACUPUNCTURE

# Healthcare Coordination Provider Information

To provide more comprehensive care for our patients, we are now offering to send your consultation and progress reports to any other healthcare providers you are seeing free of charge. We feel that keeping all of your medical practitioners involved with your progress here better serves you, our patient.

I, _____, authorize Health Discovery Acupuncture to release my medical records to the providers listed below for all dates of service/from _____ to _____. (If left blank only information from the past two years will be disclosed.)

Provider Name: _____ Phone Number:_____

Clinic Name:_____

Provider Name: _____ Phone Number:_____

Clinic Name:_____

Provider Name: _____ Phone Number:_____

Clinic Name:_____

Provider Name: _____ Phone Number:_____

Clinic Name:_____

Signature of Patient: _____ Date: _____