Patient Information Form

TRAN ACUPUNCTURE

Date				
Patient Information				
First Name		MI	□ Mr. □ Miss □ Mrs. □ Ms. □ Dr.	
Last Name		Age	Birth Date (mm/dd/yyyy)	
Marital Status □ Single □ Married □ Partner □ Divorced □ Separated □ Widowed				
Street Address			Apt./Unit	
City	State		Zip Code	
Phone Number: Home:	Work:		Email:	
Employment Status: □ F/T □ P/T □ Unemployed □ Student □ Retired □ Disabled			Occupation:	
How did you learn about us? □ Physician referral □ Friend/Family □ Internet □ Other (Please include the name of whom referred you) Name:				
Patient Medical Information				
Reason for visit:				
Height: ft. in.	Weight: (lbs.)	Primary Physician:		
Have you had acupuncture before? □ No □ Yes	Chinese herbal medicine? □ No □ Yes	Phone:		
Western medical diagnosis (if applicable):				
Other medical treatment(s) received: □ Fertility clinic □ Physical therapy □ Chiropractic □ Massage □ Other				
Please list the family members you live with:	Please list any prescription or over the counter medication you are currently taking:	Please list any herbal medicine or supplements you are currently taking:		
Have you ever been exposed or have suspicions of exposure to heavy metal toxicity? (dental work, excessive fish consumption, lead paint…) Or, toxins (mold, chemicals…)? □ No □ Yes				

How much water do you drink per day?	Are you vegetarian? □ No □ Yes

How often do you use the following?	Daily	Once/Week	Rarely	Never	How often do you participate in the following physical activities?
Tobacco					Running/Walking:
Alcohol					Swimming:
Drugs					Yoga:
Coffee					Biking:
Soft Drinks					Weight Training:
Artificial Sweeteners					Gym/Fitness Classes:

Please indicate which of the following symptoms you have had *recently* and their severity on a scale of 1-5, where 5 is the worst.

_____ Blurred/poor night vision	_____ Abdominal pain	_____ Absentminded/loss of memory
_____ Brittle nails	_____ Alternate constipation/loose	_____ Angered easily
_____ Depression/Stress	_____ Aversion to cold	_____ Annoyed by little things
_____ Dizziness	_____ Bad breath	_____ Changes in sexual energy
_____ Emotional eating	_____ Bloating/gas	_____ Considered suicide
_____ Feeling of lump in throat	_____ Bruise easily	_____ Difficulty making decisions
_____ Genital itching/pain/lesions	_____ Cold nose	_____ Difficulty relaxing
_____ Headaches/Migraines	_____ Constipation	_____ Dislike criticism
_____ Irritability/frustration/impatience	_____ Crave sweets	_____ Experienced sexual abuse
_____ Muscle twitching/spasm	_____ Difficulty getting up in the morning	_____ Family problems
_____ Neck/shoulder tension	_____ Fatigue after eating	_____ Feeling of depression
_____ PMS	_____ Foggy mind	_____ Frequent crying
_____ Red/dry/itchy eyes	_____ Heartburn	_____ Frightening dreams or thoughts
_____ Sensation or pain under rib cage	_____ Heaviness in head/body	_____ Hopeless outlook
_____ Sighing	_____ Hemorrhoids	_____ Lack of concentration
_____ Unfulfilled desires	_____ Increased appetite	_____ Lonely or depressed
_____ Visual problems/floaters	_____ Increased thirst	_____ Nail biting
_____ Ankle swelling	_____ Intestinal pain/cramping	_____ Nervous with strangers
_____ Bladder infection	_____ Loose stool	_____ Nervousness or anxiety
_____ Cold hands/feet	_____ Muscular tired/weak	_____ Problems at work
_____ Crave salty food	_____ Nausea/vomiting	_____ Sexual difficulties
_____ Fear	_____ Overweight	_____ Shy or sensitive
_____ Feel cold easily	_____ Pensive/over-thinking	_____ Sought psychiatric help
_____ Frequent urination	_____ Poor appetite	_____ Worry a lot
_____ Hearing problems	_____ Poor digestion	_____ Allergies/Asthma
_____ High sex drive	_____ Prefer warm/cold drink	_____ Alternate fever/chills
_____ Lack of bladder control	_____ Sweat easily	_____ Cough with phlegm
_____ Loss of head hair	_____ Unusual bleeding (nose, anus, etc)	_____ Dry cough
_____ Low sex drive	_____ Water retention	_____ Dry mouth/nose/throat
_____ Night sweats/hot flashing	_____ Yeast infection	_____ Grief/sadness
_____ Poor long-term memory	_____ Aversion to heat	_____ Itchy/painful throat
_____ Tinnitus	_____ Bitter taste in mouth	_____ Nasal discharge/drip
_____ Wake to urinate	_____ Chest pain/tightness	_____ Shortness of breath
_____ Insomnia/sleep problems	_____ Forgetful	_____ Sinus infection/congestion
_____ Lack of joy in life	_____ Palpitations	_____ Skin rashes/hives
_____ Restless/easily agitated	_____ Tongue/mouth ulcers/cankers	_____ Weak immune system
_____ Snoring	_____ Vivid dreams	_____ Other:

Occupation: please explain your duties and stress levels involved.

Personal impact: please explain any personal stresses in your life.

Passions and hobbies:

Patient Information Form (continued)

Patient Name: _____

Print the names of relative (living or deceased) in the rows to the left. Place an [X] in the appropriate column for any illnesses that you or the relatives listed have had.

Were you adopted? □ No □ Yes	Allergies	Anemia	Anorexia	Arthritis/Gout	Asthma	Bleeding/Bruising Problem	Bulimia	Cancer or Tumors	Convulsions/Epilepsy	Diabetes	Drinking or Drug Problems	Eczema	Emphysema	Gallstones	Heart Trouble	Hepatitis	High Blood Pressure	Infertility	Frequent Infections	Kidney or Bladder Problem	Mental Illness	Migraines	Abnormal Periods	Psoriasis	Polio	Prostate Problems	Rheumatic Fever	Stomach or Intestinal	Stroke	Thyroid Problems	Tuberculosis	Ulcers	Venereal Disease
Self																																	
Mother																																	
Father																																	
Siblings (list)																																	
Children (list)																																	
Grandparents																																	

Have you had any other significant illnesses?

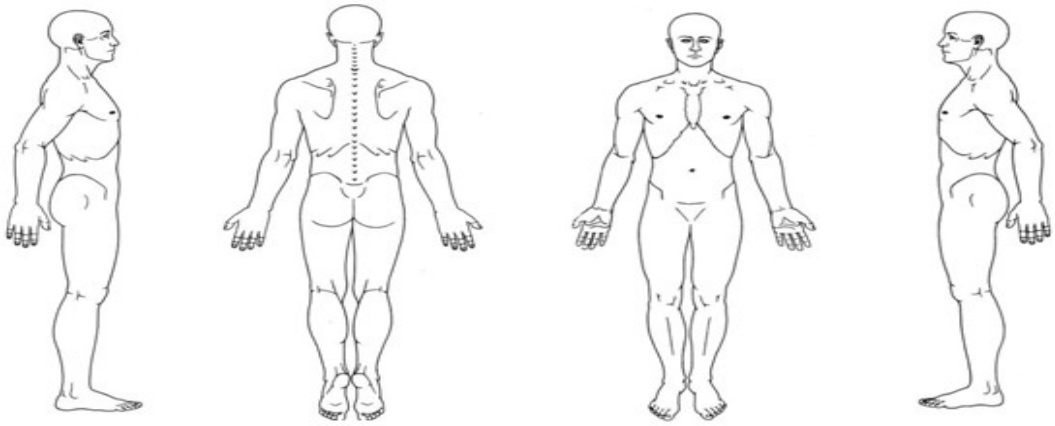
Have you had any surgeries or been hospitalized?

Have you had any significant trauma (accidents, injuries, etc.)?

Do you have any allergies (drugs, chemicals, food, etc.)?

Please indicate painful or distressed areas with:

N=Numbness **P**=Pins and Needles **S**= Stabbing Pain **A**= Achy **T**= Tightness



(right side) (back) (front) (left side)

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, 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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. 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 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 (which are from plant, animal, and mineral sources) that have been recommended 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, 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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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 NAME:

ACUPUNCTURIST NAME: Hannah Tran, L.Ac., Dipl. Ac., MSOM

PATIENT SIGNATURE: **X** DATE:

(Or Patient Representative) (indicate relationship if signing for patient)

PATIENT CANCELLATION & FINANCIAL POLICY

We are committed to providing you with quality health care. Your clear understanding of our Patient Cancellation and Financial Policy is important to our professional relationship.

Cancellation/No Show. If you need to reschedule or cancel your appointment, to avoid a $45 cancellation fee, you must call the office and/or acupuncturist directly with at least 24 hours advance notice. Patients who do not arrive for their appointments and have not called ("no call/no show") will be charged the full price of the missed session, payable before the next appointment can be scheduled.

Insurance. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required if we can't verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. You must pay for these services in full at the time of visit or it may be billed to you after.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment. If you are sent a statement/invoice from our office, and no resolution can be made, the account will be sent to the collection agency, and you will be discharged from the practice.

Self-Pay Accounts. Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. Full payment is due at the time of service.

By voluntarily signing below, I show that I have read and understand the policies stated above.

PATIENT NAME:

PATIENT SIGNATURE: **X** DATE:

(Or Patient Representative) (indicate relationship if signing for patient)