Mind & Body Natural Healing Center
2115 SE 192nd Avenue Suite 108
Camas, WA 98607
(360) 833-2868

Welcome to Mind & Body Natural Healing Center. We look forward to working with you to improve your health. Acupuncture is a holistic medicine that works on physical, mental, emotional and spiritual levels. The purpose of treatment is to bring balance to all of these levels.

PATIENT INFORMATION

Name_____

Age____ DOB_____ Sex____

Address_____

City_____ State_____ Zip_____

Home phone_____

Employer's Name _____

Patient marital status _____

In emergency notify _____

Phone number _____

Do you have dual-coverage insurance?_____

If yes, what is the name?_____

Whom may we thank for the referral?

_____

POLICY HOLDER'S INFORMATION

Patient's medical I.D. number_____

Policy Holder's name _____

Patient's relationship to Policy Holder _____

Policy Holder's address_____

City _____State_____Zip_____

Policy Holder's home phone_____

Policy Holder's work phone _____

Policy Holder's policy group number_____

Policy Holder's DOB_____Sex _____

Policy Holder's Employer Name_____

Insurance Company's name_____

Have you tried Acupuncture or Chinese Herbal Medicine before?

_____

Email Address:_____@_____

PLEASE READ AND SIGN THE FOLLOWING

I voluntarily authorize the acupuncturist to administer acupuncture and/or other treatments of oriental medicine for relief of my disorders. I understand that appointment times are reserved especially for me and that $45 is charged for missed appointments and the $25 fee is charged for same day cancellations. Payment is due prior to future treatments. I also understand that if I miss an appointment and/or cancel an appointment on the same day three times, that all of my future appointments will be canceled.

I understand that payment is due at the beginning of each visit, unless otherwise arranged. (If we are not sure of your insurance co-pay or coverage, we ask for full payment until this is determined) There will be a $25.00 fee charged on all returned checks.

I have read and understand the above. Please sign below to authorize insurance payment, if billing medical insurance. I authorize Mind & Body Natural Healing Center to accept assignment for medical service(s) rendered.

Signed_____ Date_____

GENERAL

Weight _____ lbs. Weight 1 year ago _____ lbs. Maximum weight _____ lbs Height _____

Blood pressure _____ Pulse _____ Temperature _____

When during the day is your energy the best? _____ Worst? _____

PAST MEDICAL HISTORY

__ Allergies __ Cancer __ Diabetes __ Hepatitis __ High blood pressure __ Heart disease

__ Seizures __ Thyroid disease __ Surgeries_____ other significant illnesses_____

__ Accidents or trauma _____

FAMILY HISTORY (check those applicable)

__ Cancer __ Diabetes __ Heart Disease __ High blood pressure __ Stroke __ Epilepsy

__ Mental Illness __ Asthma __ Hay-fever __ Hives __ Anemia __ Kidney Disease

__ Glaucoma __ Tuberculosis __ Thyroid Disease

LIFESTYLE

Do you follow a regular exercise program? _____ If so, please describe:_____

Please describe your average daily diet: _____

Please check any of the following habits that apply. Indicate how much and how often your consume them.

__ Cigarette smoking_____ __ coffee, tea or cola _____

__ Alcoholic beverages _____

HEALTH HISTORY QUESTIONAIRE

Main problem(s) you would like to address:

_____ _____

_____ _____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)

_____

How long has it been since you first noticed any symptoms? _____

What kinds of treatment have you tried? _____

Medications taken within the last two months _____

Please put a check next to conditions you have experienced within the last three months. Indicate the length of time you have had this condition:

GENERAL

□ Poor appetite _____ □ Insomnia _____ □ Disturbed sleep _____
□ Localized weakness _____ □ Cravings _____ □ Strong thirst _____
□ Weight gain _____ □ Weight loss _____ □ Changes in appetite _____
□ Sweating easily _____ □ Tremors _____ □ Bleeding or bruising easily __
□ Night sweats _____ □ Fever _____ □ Chills _____
□ Sudden energy drop (time of day?) _____ □ Poor balance _____
□ Other unusual or abnormal conditions you have noticed in your general sense of health? _____
_____

SKIN AND HAIR

□ Rashes _____ □ Ulcerations _____ □ Hives _____
□ Itching _____ □ Eczema _____ □ Pimples _____
□ Dandruff _____ □ Hair loss _____ □ Recent moles _____
□ Changes in hair or skin texture _____
Any other hair or skin problems? _____

HEAD, EYES, EARS, NOSE, THROAT

□ Dizziness _____ □ Concussions _____ □ Migraines _____
□ Glasses _____ □ Spots in front of eyes ____ □ Eye pain _____
□ Poor vision _____ □ Night blindness _____ □ Color blindness _____
□ Cataracts _____ □ Blurry vision _____ □ Earaches _____
□ Ringing in ears _____ □ Poor hearing _____ □ Eyestrain _____
□ Sinus Problems _____ □ Recurrent sore throat _____ □ Nose bleeds _____
□ Grinding teeth _____ □ Sores on lips or tongue ____ □ Facial pain _____
□ Teeth problems _____ □ Headaches (Where? When?)__ □ Jaw clicks _____
Any other head or neck problems? _____

CARDIOVASCULAR

□ Dizziness _____ □ Low blood pressure _____ □ Chest pain _____
□ Irregular heartbeat _____ □ High blood pressure _____ □ Fainting _____
□ Cold hands or feet _____ □ Swelling of hands _____ □ Swelling of feet _____
□ Blood clots _____ □ Difficulty in breathing _____ □ Phlebitis _____
Any other heart of blood vessel problems? _____

RESPIRATORY

□ Cough _____ □ Coughing up blood _____ □ Asthma _____
□ Bronchitis _____ □ Pain with deep inhalation ___ □ Pneumonia _____
□ Difficulty breathing when lying down _____ □ Production of Phlegm (Color?) _____
Any other lung problems? _____

GASTROINTESTINAL

□ Nausea _____ □ Vomiting _____ □ Diarrhea _____
□ Constipation _____ □ Gas _____ □ Belching _____
□ Black stools _____ □ Blood in stools _____ □ Indigestion _____
□ Bad breath _____ □ Rectal pain _____ □ Hemorrhoids _____
□ Abdominal pain or cramps _____ □ Chronic laxative use _____
□ Any other problems with stomach or intestines? _____

GENITO-URINARY

□ Pain on urination _____ □ Frequent urination _____ □ Blood in urine _____
□ Urgency to urinate _____ □ Unable to hold urine _____ □ Kidney stones _____
□ Decrease in flow _____ □ Impotence _____ □ Sores on genitals _____
□ Do you wake up at night to urinate? _____ If so, how often? _____
Any particular color to your urine? _____
Any other problems with your genital or urinary functions? _____

REPRODUCTIVE AND GYNECOLOGIC

□ Menstrual clots _____ □ Painful menses _____ □ Unusual menses
□ Changes in body/psyche prior to menstruation _____ (heavy or light?) _____
□ Irregular menses _____ □ Menopause (age?) _____ □ Other problems _____
Age at first menses _____ Length of time between menses _____ Duration _____
First day of last menses _____ Number of pregnancies _____ Premature births _____
Miscarriages _____ Abortions _____ Number of births _____
Do you practice birth control? ____ If so, what type? _____ For how long? _____

MUSCULOSKELETAL

□ Neck pain _____ □ Muscle pains _____ □ Knee pain _____
□ Back pain _____ □ Muscle weakness _____ □ Foot/ankle pain _____
□ Hand/wrist pains _____ □ Shoulder pains _____ □ Hip pain _____
Any other joint or bone problems? _____

NEUROPSYCHOLOGICAL

□ Seizures _____ □ Dizziness _____ □ Loss of balance _____
□ Areas of numbness _____ □ Poor memory _____ □ Lack of coordination _____
□ Concussion _____ □Depression _____ □ Anxiety _____
□ Bad temper _____ □ Easily susceptible to stress _____
Have you ever been treated for emotional problems? _____
Have you ever considered or attempted suicide? _____
Any other neurological or psychological problems? _____

COMMENTS

Please tell us of any other problems you would like to discuss: _____
_____

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HIPPA FORM

HIPAA - Notice of privacy practices

In accordance with The Health Information Privacy and Accountability Act (HIPAA), all healthcare providers are required by law to maintain the privacy of your health information and provide you a description of their privacy practices. This notice identifies your rights regarding the center's use of your protected Health Information. This notice also describes how your health information may be used and disclosed, and how you can get access to this information.

Each time you visit Mind & Body Natural Healing Center a record of your visit is made. The clinic will use and disclose health information about treatment and services you receive so that we can bill and receive payment. We will also tell your insurance company about treatment you are going to receive to determine whether your plan will cover it.
Information about your treatment and services may also be disclosed to your attorney if an attorney is involved in litigation regarding the medical necessity of medical massage and the liability of payment.
Although your health record it the physical property of Mind & Body Natural Healing Center, you have the right to inspect and upon written request, obtain a copy for a fee of your health information which usually includes prescriptions and medical and billing records.

If you believe that health information we have about you is incorrect or incomplete, you may request in writing that we amend your health information.
Our disclosure of your health information is limited to your insurance company, your attorney, your treating physicians, and you. If the patient is a minor or has a legal guardian, a parent or guardian is required to read this notice and sign for the patient, and the patient health information will be disclosed to the parents or guardian.
If you believe your privacy rights have been violated, you may file a written complaint to the office of civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue SW., Room 509 F, HHH Building, Washington D.C. 20201.
By signing this form you hereby acknowledge that Mind & Body Natural Healing Center may release your Protected Health Information to carry out payment and treatment operations.
I have read and understand the Notice of Privacy Practices of Mind & Body Natural Healing Center.

_____/_____

Patient/Patient Representative Signature Date Signed

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PLEASE READ AND SIGN THE FOLLOWING

Explanation of Insurance Coverage:
Many insurance policies do not cover acupuncture care and this office makes no representation that yours does. Insurance policies may vary greatly in terms of deductible and percentage of coverage for care. Because of the variance from on Insurance policy to another, we require that you, the patient, be personally responsible for any and all charges accrued during care here. This includes but is not limited to deductibles, co-insurance, copays, herbs and any other unpaid balances acquired in this office. We will do our best to verify your insurance coverage; however verification is not a guarantee of payment. We will do our best to bill insurance and you, the patient, in a timely manner.

Assignment of Benefits:
By signing below you assign benefits to Mind & Body Natural Healing Center. This designation directs your insurance company to send payments directly to this office. If your insurance carrier sends payment to you for services incurred at this office, you agree to send or bring those payments to this office upon receipt. If you pay for your visits in full the assignment need not be signed and the payments will be sent directly to you from your insurance.

Release of Information:
If you're insurance company requires medical reports or records to document your treatment or progress, your signature below authorizes this office to release the necessary medical information to process your claim.

Voluntary Termination of Care:
If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are charged directly to you, and you, ultimately will be personally responsible for payment regardless of your insurance coverage.

Copay-Coinsurance-Deductibles-Returned Checks:
I understand that payment is due at the beginning of each visit, unless otherwise arranged. (If we are not sure of your insurance coverage, co-pay or deductible, we ask for full payment until this is determined.) There will be a $25 fee on all returned checks. If balance on account is not paid when due, the patient shall pay reasonable costs of collection, including collection agency fees/interest.
I have read and understand the above. Please sign below to authorize insurance payment, if billing medical insurance. I authorize Mind & Body Natural Healing Center to accept assignment for medical services rendered.

We would like to take a moment to welcome you to our office and assure that you will receive the very best of care available for your condition.

I have read and agree to the above terms.

Print Full Name_____ Date_____

Signature_____

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East Asian medicine means a health care service using East-Asian-Medicine diagnosis and treatment to promote health and treat organic or functional disorders.

I am a licensed Acupuncturist in the state of Washington and my license number is 00000754.

The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following:

1.) Acupuncture; I understand that acupuncture is performed by the insertion of needles at certain points on the surface of the body in an attempt to treat bodily dysfunction or disease, to modify or prevent pain perception and to normalize the body's physiological function.
2.) Electro-Acupuncture
3.) Moxibustion
4.) Cupping
5.) Chinese Herbs
6.) Acupressure-Massage
7.) Dermal friction technique
8.) Infra-red
9.) Sonopuncutre
10.) Laserpuncture
11.) Point Injection therapy
12.) Breathing, relaxing, and East Asian Techniques
13.) Qi Gong
14.) Superficial Heat Therapies

Side effects include but are not limited to:

1.) Pain following treatment
2.) Minor bruising
3.) Infection
4.) Needle sickness
5.) Broken needles

I understand that there is no guarantee concerning the use and effectiveness of acupuncture and Oriental medicine that are given to me and that I am free to stop treatment at any time. I have carefully read and understand all of the above information and I am fully aware of what I am signing. If a more detailed explanation is needed, please ask. I give my permission and consent to my treatment.

Printed Name:_____ Date of Birth:_____

Signature:_____ Date:_____