ACUPUNCTURE WEST

PATIENT MEDICAL HISTORY
Confidential

General Information

Name (First, Middle Initial, Last):_____

Address:_____ City:_____

State:_____ Zip Code:_____ Home Phone:_____

Work Phone:_____ Other Phone:_____

Email Address:_____ (*Your email address is kept secure and not shared with anyone.*)

Gender:_____ Age:_____ Date of Birth:_____ Marital Status:_____

Height:_____ Weight:_____ Occupation:_____

Who is your medical doctor?_____ Date of last visit:_____ Reason:_____

Have you received acupuncture/Chinese herbs in the past?_____

Major Complaint

What is your primary reason for this visit?

_____

_____

_____

What do you think is the cause of this condition?

_____

How long have you had this condition?_____ Is it getting worse?_____

What seems to make it better?_____

What seems to make it worse?_____

Does this condition interfere with your ☐ Sleep ☐ Work ☐ Other_____

Have you received treatment for this complaint? ☐ Yes ☐ No

If yes, what was done?_____

Did it help? ☐ Not at all ☐ Somewhat ☐ Very effective ☐ Not sure

Do you have any specific questions that you would like to discuss today?_____

_____

_____

_____

Family Health History

Place a mark to indicate if a *blood relative* has had any of the following:

☐ Alcoholism	☐ Asthma	☐ Diabetes	☐ Seizures
☐ Allergies	☐ Cancer	☐ Heart Disease	☐ Stroke
_____	_____	☐ High Blood Pressure	☐ Vascular Disease

Your Health History

Place a mark to indicate if *you* have had any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Jaundice	☐ Obesity	☐ Thyroid Disorders
☐ Alcoholism	☐ Epilepsy	☐ Kidney Disease	☐ Pacemaker	☐ Tuberculosis
☐ Allergies	☐ Glaucoma	☐ Measles	☐ Pneumonia	☐ Typhoid Fever
☐ Asthma	☐ Heart Disease	☐ Meningitis	☐ Polio	☐ Ulcers
☐ Bleed Easily	☐ Hepatitis	☐ Mental Disorder	☐ Rheumatic Fever	☐ Vascular Disease
☐ Cancer	☐ High Blood Pressure	☐ Migraines	☐ Scarlet Fever	☐ Venereal Disease
☐ Chicken Pox	☐ High Fevers	☐ Multiple Sclerosis	☐ Seizures	
☐ Colitis	☐ IBS	☐ Mumps	☐ Stroke	

Male (♂)

☐ Impotence ☐ Nocturnal emissions ☐ Premature ejaculation

Female (♀)

Age menses began:_____
Days of menstrual flow:_____
Length of cycle (day 1 to day 1):_____
Number of pregnancies: _____
Number of live births:_____
Number of premature births:_____
Age at menopause:_____

☐ Vaginal discharge
☐ Irregular periods
☐ Painful periods
☐ Clots in menstrual blood
☐ PMS
Date of last PAP:_____
Date last period began:_____

Additional Questions

List any medications you are currently taking:_____

_____

List illnesses for which you have been hospitalized:_____

_____

_____

List any other serious injuries, broken bones, scars, etc:_____

_____

List allergies or sensitivity to any medicines or other substances:_____

_____

Comments (anything else you would like to tell us):_____

_____

How did you hear about us?_____

_____

I authorize treatment by the practitioners at Acupuncture West, LLC. All information on this form is correct to the best of my knowledge. I understand that I am responsible for payment of applicable fees to Acupuncture West, LLC on the day that services are rendered unless other arrangements have been made in advance.

_____ _____

PATIENT SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

INFORMED CONSENT FOR ORIENTAL MEDICAL TREATMENT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of Oriental medicine on me (or on the patient named below for whom I am legally responsible) by the licensed acupuncturists named 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 practitioners named below, including those working at Acupuncture West, LLC or any other office or clinic, whether signatories to this form or not.

There are some risks to treatment, including but not limited to some bruising of the skin and/or slight bleeding. If moxibustion or heat therapies are used there is a risk of burn and/or scarring. The risk of infection is small when all needles are sterile and Clean Needle Technique procedures are followed. I understand that all practitioners at Acupuncture West, LLC are certified in Clean Needle Technique and use only sterile, single-use, disposable needles.

I have had an opportunity to discuss with the practitioner the nature and purpose of Oriental Medicine. I understand that results are not guaranteed.

I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgment which the practitioner feels at the time is in my best interest, based upon the facts then known, during the course of the procedure.

I understand that I have the choice to accept or reject the proposed diagnostic procedure or treatment, or any part of it, before or during the diagnosis or treatment.

I understand that the practitioner is not providing Western (allopathic) medical care, and that I should look to my Western primary care practitioner (i.e. MD) for those services and for routine check-ups.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. 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 SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

FINANCIAL POLICIES

DESCRIPTION OF SERVICE	FEE
For Acupuncture and/or BodyTalk:	
Initial Visit (90 minutes)	$ 135
Follow-up Visit (60 minutes)	$ 100
Herbal Prescription or Essential Oil Formula	Variable

- You are expected to make full payment at the time of service.
- Your appointment time is reserved specifically for you. **PLEASE PROVIDE *AT LEAST 24 HOURS NOTICE* IF YOU MUST CANCEL AN APPOINTMENT; OTHERWISE YOU WILL BE CHARGED A MISSED APPOINTMENT FEE OF $50. Please initial _____**
- Acupuncture West LLC accepts cash, check, Visa, MasterCard, and Debit Card.
- We charge a fee of $30 for all checks returned due to insufficient funds.

Insurance Information:

- If your insurance covers acupuncture, we will provide you with a Superbill (an itemized insurance receipt) which you may submit to your insurance company and the insurance company will reimburse you directly. You are expected to make full payment at the time of service.
- If you would like a Superbill to submit to your insurance company, please tell us at the time you make your appointment.

Please indicate your understanding and acceptance of these policies by signing below.

_____ _____

PATIENT SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

I consent to the use or disclosure of my identifiable health information by Acupuncture West, LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills, or to conduct health care operations. I understand that diagnosis or treatment of me at Acupuncture West, LLC may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment, or health care operations of the practice. Acupuncture West, LLC is not required to agree to the restrictions that I may request. However, if Acupuncture West, LLC agrees to a restriction that I request, the restriction is binding upon Acupuncture West, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that Acupuncture West, LLC has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Acupuncture West, LLC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Acupuncture West, LLC. The Notice of Privacy Practices is also provided at the front desk. This Notice of Privacy Practices also describes my rights and the duties of my practitioners and Acupuncture West, LLC with respect to my identifiable health information.

Acupuncture West, LLC reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by requesting the most current notice during any office visit.

_____ _____

PATIENT SIGNATURE (Or Patient Representative) **DATE**
(Indicate Relationship If Signing For Patient)

NOTICE OF PRIVACY PRACTICES

Our Clinic Protects Your Health Information and Privacy

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with worker's compensation (and your employer as well in this instance), or with other medical practitioners *that you authorize*.

Safeguards in place at our office include:

- Limited access to facilities where information is stored.
- Policies and procedures for handling information.
- Requirements for third parties to contractually comply with privacy laws.
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

Types of information that we gather and use:

- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
- About your financial transactions with us (billing transactions).
- From health care providers, insurance companies, worker's compensation and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

We value our relationship and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (208) 377-1455.

Best regards,
Jennifer Games, PT, L. Ac.
Acupuncture West, LLC