New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. If you have any questions or concerns, please do not hesitate to ask us. Thank you.

CIRCLE ACUPUNCTURE
PAIN & STRESS TREATMENT

Patient Name _____ **Date** _____

General Information

Address _____ City _____ State _____

Home Phone _____ Occupation _____ Zip _____

Work Phone _____ Mobile Phone _____ Date of Birth _____

Email Address _____

We value your privacy and from time to time we send out email, text and mail communication updates, some may be very important and timely, would you like to receive:

Emails ☐ Yes ☐ No
Texts ☐ Yes ☐ No
Mail ☐ Yes ☐ No

Emergency Contact _____ Relationship _____ Phone _____

Have you had Acupuncture or Oriental medicine before? ☐ Yes ☐ No

Family Physician _____ Phone _____

What was your experience? ☐ Very good ☐ Good ☐ No change

☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Single

Are you presently under a doctor's care? ☐ Yes ☐ No Who and what for? _____

Are there any other therapies which you are involved in? ☐ Yes ☐ No Who and what for? _____

Insurance Information

Insurance Company _____ Phone _____ Date Called _____

ID # _____ Co-Pay $ _____ Covered % _____

Visit # _____ Deductible Amount _____

Contact Name _____ Referral ☐ Yes ☐ No

Focus

What is the primary reason for seeking care at our office? _____

What was the initial cause? _____

When did it begin? _____

What makes it worse? _____

What makes it better? _____

How does this problem interfere with your daily activities?

☐ Work ☐ Sleep ☐ Walking ☐ Sitting
☐ Standing ☐ Emotional ☐ Relationships ☐ Social Life
☐ Sexually ☐ Recreation ☐ Bending ☐ Stretching
☐ Other _____ _____

What have you done about this? _____

Are you interested At this clinic :

☐ Pain Relief ☐ Preventative Care ☐ Oriental Nutrition
☐ Holistic Health ☐ Stretching/Yoga ☐ Maintenance Care
☐ Stress Relief ☐ Herbal Therapy
☐ Other _____ _____

What are your health goals? _____

List any past or future surgeries: _____

List any significant trauma & when it occurred (e.g. auto accident, falls, emotional, sexual, etc.): _____

List exercise and sport activities you have been or are currently involved in: _____

Medical History

Do you have any allergies? ☐ Yes ☐ No If so, to what? _____

Do you take medication? ☐ Yes ☐ No If so, what types and how often? _____

Do you take supplements? ☐ Yes ☐ No If so, what types and how often? _____

Please indicate if you or any family members have or had any of the following conditions:

☐ Pneumonia	☐ Drug reaction	☐ Mental breakdown	☐ Gonorrhea/Herpes	☐ Mental illness
☐ Tuberculosis	☐ Heart attack	☐ Jaundice	☐ HIV/AIDS	☐ Hypo/hyper thyroid
☐ Hepatitis	☐ Blood transfusion	☐ Parasites	☐ High/low blood pressure	☐ Premature graying
☐ Diabetes	☐ Anemia	☐ Measles	☐ Heart disease	☐ Seizures
☐ Epilepsy	☐ Arthritis	☐ Mumps	☐ Gout	☐ Multiple Sclerosis
☐ Kidney Stone	☐ Obesity	☐ Syphilis	☐ Cancer	

Do you sleep well? ☐ Yes ☐ No Do you dream? ☐ Yes ☐ No

Do you have a high point during the day? ☐ Yes ☐ No When? _____ Do you have a low point during the day? ☐ Yes ☐ No When? _____

What are your indulgences? _____

What are your hobbies/pleasures? _____

Female Concerns

Date of last menstruation _____ Is your cycle regular? ☐ Yes ☐ No Is your cycle painful? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Birth control? ☐ Yes ☐ No How long? _____

☐ PMS ☐ Clotting ☐ Vaginal sores ☐ Vaginal pain ☐ Discharge

Other _____

Male Concerns

☐ Testicle pain ☐ Penis pain ☐ Penis sores ☐ Discharge ☐ Premature ejaculation ☐ Nocturnal emission ☐ Impotence

Other _____

Signs/Symptoms

☐ Abdominal pain/distention	☐ Coughing blood	☐ Hemorrhoids	☐ Muscle cramps/pain	☐ Sinus pressure
	☐ Dark stools	☐ Heart palpitations	☐ Nasal congestion	☐ Skin fungal infection
☐ Abuse survivor	☐ Decreased libido	☐ Hiccup	☐ Neck/shoulder pain	☐ Spots in eyes
☐ Acid regurgitation	☐ Depression	☐ High blood pressure	☐ Night sweat	☐ Sweat easily
☐ Acne	☐ Dizziness/vertigo	☐ Increased libido	☐ Nose bleeds	☐ Sore throat
☐ Asthma	☐ Dry throat/mouth	☐ Indigestion	☐ Numbness	☐ Sudden energy drop
☐ Bad breath	☐ Diarrhea	☐ Intestinal pain/cramps	☐ Odorous stools	☐ Swollen glands
☐ Blood in stools	☐ Ear aches	☐ Irritable	☐ Pain upon urination	☐ Teeth/gum problems
☐ Blood in urine	☐ Enlarged thyroid	☐ Itchy eyes	☐ Peculiar tastes	☐ Ulcerations
☐ Blurry vision	☐ Eye pain/strain/tension	☐ Itchy skin	☐ Poor appetite	☐ Upper back pain
☐ Breast lump/pain	☐ Excessive phlegm	☐ Joint pain	☐ Poor circulation	☐ Urgent urination
☐ Bruise easily	Color of _____	☐ Kidney stones	☐ Poor memory	☐ Vomiting
☐ Chest pains	☐ Excessive saliva	☐ Laxative use	☐ Poor sleep	☐ Wake to urinate
☐ Chills	☐ Fatigue	☐ Limited range of motion	☐ Psoriasis	☐ Weight loss/gain
☐ Cold hands/feet	☐ Fever	☐ Loss of hair	☐ Rash	☐ Wheezing
☐ Concussion	☐ Frequent urination	☐ Low back pain	☐ Redness of eyes	☐ Other: _____
☐ Confusion	☐ Gas/belching	☐ Migraine	☐ Seizures	_____
☐ Constipation	☐ Grinding teeth	☐ Mouth sores	☐ Short temper	_____
☐ Cough	☐ Headache	☐ Mucus in stools	☐ Shortness of breath	_____

Pain

Use the diagram and pain key to the right to indicate areas and type of pain.
Use the chart below to indicate pain intensity and limitations.

Pain intensity levels (1 to 10 of 10)

1 2 3 4 5 6 7 8 9 10

Sleeping

☐ No problem ☐ Disturbed ☐ Very disturbed ☐ Cannot sleep

Work - Can do:

☐ Usual work ☐ 50% of work ☐ 25% of work ☐ No work

Frequency of pain

☐ 25% of time ☐ 50% of time ☐ 75% of time ☐ 100% of time

Travel

☐ No problem ☐ Moderate pain on trips ☐ Severe pain

Recreation - Can do:

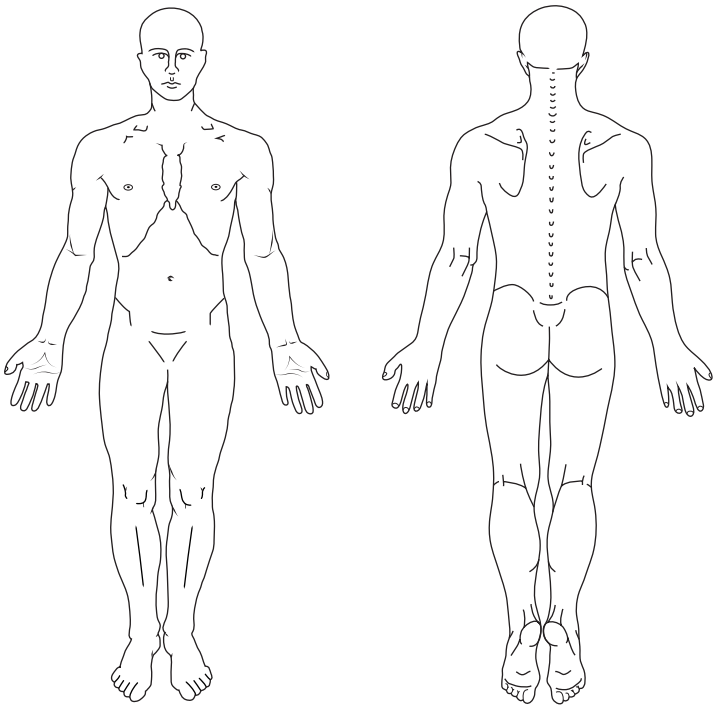
☐ All activities ☐ Some activities ☐ No activities

Walking

☐ Can walk fine ☐ Pain after 1/2 mile ☐ Cannot walk

Sitting

☐ No pain sitting ☐ Some pain while sitting ☐ Cannot sit



Pain Key

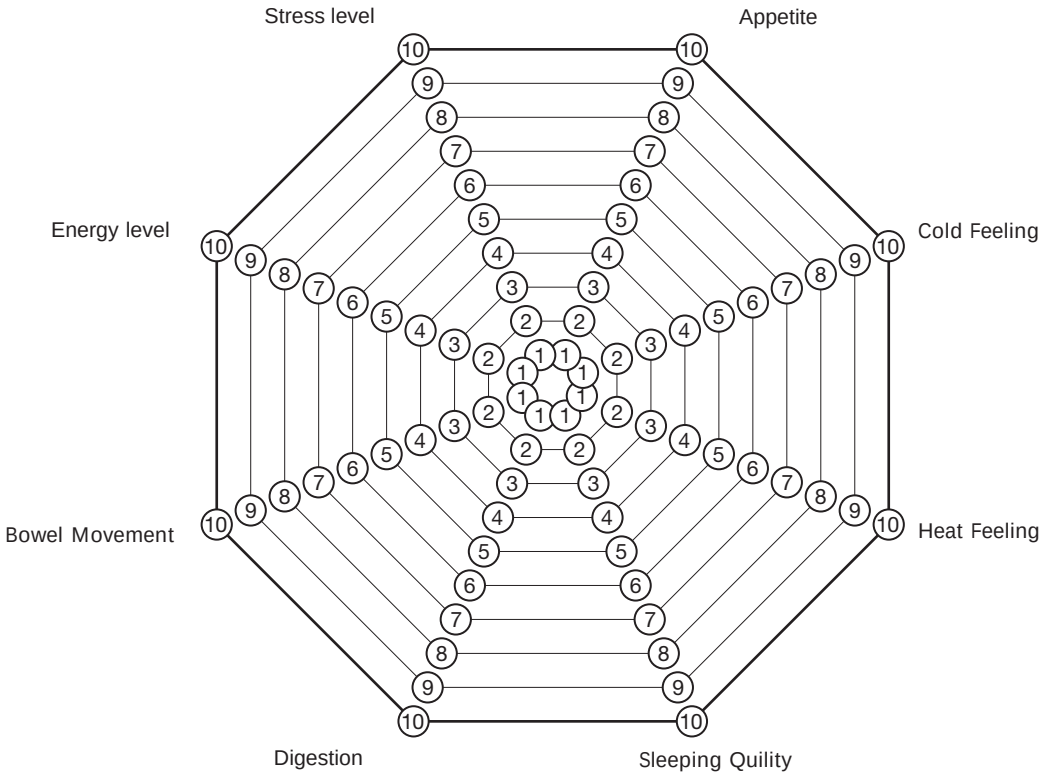
Ache	Numbness	Pins & Needles	Burning	Stabbing
^ ^ ^ ^	= = = =	0 0 0 0	X X X X	/ / / /

Web of Wellness

Health and wellness are a balance of many things. Many factors affect our lives in various ways. These factors weave a web of health and well-being.

Using the diagram to the right, choose your level of satisfaction in each of the areas. For example, if you are extremely satisfied with your career, shade in the “10” circle on the career health line.

1 = Extremely unsatisfied
5 = Neutral
10 = Extremely satisfied



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

not committed 1 2 3 4 5 6 7 8 9 10 very committed

Terms of Acceptance

Acupuncture is an effective form of health care that has evolved into a complete and holistic medical system. Acupuncturists and practitioners of Traditional Chinese Medicine (TCM) use this non-invasive healing modality to help millions of people get well and stay healthy.

When a patient seeks Acupuncture care and is accepted as a patient for such care, it is essential for both patient and Acupuncturist to be working toward the same objectives in order to prevent any confusion or disappointment.

The main objective of Acupuncture is to determine where there are imbalances in the body as they relate to TCM. When the flow of Qi (the vital energy that flows throughout the body) is disrupted, illness and disease may occur. An imbalance in any of the 14 main Meridian channels causes an alteration in the flow of Qi through the body. This can result in a lessening of the body's innate ability to heal itself and express maximum health potential.

Once imbalances are detected, various treatment modalities may be employed to correct these imbalances. Any health condition(s) or disease(s) presented by the patient will be treated according to TCM only and treatment will relate only to the quantity, quality and balance of Qi.

The ONLY practice objective is to detect and correct imbalances within Meridian channels using Acupuncture and TCM techniques.

Patients will be advised if a non-Acupuncture related or otherwise unusual finding is encountered during the course of an Acupuncture examination. If advice, diagnosis or treatment of those findings is desired, patients will be referred to a qualified health care professional.

I, _____, have read and fully understand the above statements.

All questions regarding the acupuncturist's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept Acupuncture care under these terms.

Signature _____ Date _____

Office Use Only

BP: PR: Tongue: Pulse: Wt: Ht:

Colorado Mandatory Disclosure Statement

Circle MindBody Acupuncture, 3090 S. Jamaica Ct, #308, Aurora, CO 80014 | (303) 210-5717

Bup Lee, L.Ac., PhD - Bup Lee is a nationally licensed acupuncturist with a Diplomate in Oriental Medicine and Chinese Herbology. He received his Master of Science in Oriental Medicine (M.S.O.M.) from South Baylo University in Los Angeles, CA after 3,950 hours of study. He attained his Dotoral degree in Oriental Medicine and Acupuncture in 2019 from American Univercity in California. He is board-certified to practice acupuncture and Chinese Herbology by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). He received his license to practice in the state of Colorado in 2019 (2016 in California). His license, certificate, or registration have never been revoked or suspended.

This clinic complies with the rules and regulations promulgated by the Colorado Department of Health, including the proper cleaning, sterilization, sanitation of acupuncture offices. Only single-use, disposable, factory-sterilized needles are utilized.

Fee Schedule - Discounted Fees for Cash Pay

Initial intake consultation and acupuncture treatment (60-70 minutes)- $130

Follow-up acupuncture treatment (60 minutes) - $100

Health Insurance patient (40-50 minutes)

Herbal supplements are additional to the above charges. There is a 15-day return policy on UNOPENED herbs.

Initial _____

Please note that we have a 24-hour cancellation notice policy. Missed appointments or appointments cancelled within 24 hours of your scheduled appointment will be charged according to the above fee schedule.

Initial _____

Your rights as a patient:

- As a patient you are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

- As a patient you may seek a second opinion from another healthcare professional or may terminate therapy at any time.

- In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

- Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 of the Colorado Revised Statutes, and the HIPAA Notice of Privacy Rights you were provided as well as other exceptions in Colorado and Federal law. For example, mental health professionals are required to report suspected child abuse to authorities. If a legal exception arises during therapy, if feasible, you will be informed accordingly.

The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have comments, questions, or complaints, contact the Acupuncture Registration Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202. Telephone (303) 894-7800.

I have read and understand this document. I certify that I have had the opportunity to have any and all questions answered about this information and I freely seek the services offered.

Printed name _____ Signature _____ Date _____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatment and other procedures within the acupuncture scope of practice on me (or on the patient named below for whom I am legally responsible) by the acupuncturist below.

I understand that methods of treatment may include but are not limited to, **acupuncture, moxibustion directly or indirectly applied on skin, cupping, guasha, electrical stimulation, Oriental massage,Tui-Na (acupressure), Oriental herbal medicine, and/or 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 unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is generally safe method of treatment, but that it may have **some side effects including pain, bruising, numbness, swelling or tingling sensation near the needling sites that may last a few days or sometimes/rarely over 1-6 months and dizziness or fainting.**

Bruising and, or scarring, blisters are a common side effect of cupping/or guasha and, or blood letting with cupping, Cupping: prick bleed using a lance to dramatically enhance blood or qi movement; this will cause bleeding and may also cause local bruising or swelling, scarring, blisters and may last a few days or sometimes/rarely over 1-6 months.

Burns, blisters, and, or scarring are a potential risk of moxibustion burning moxa and may last a few days or sometimes/rarely over 1-6 months. After Tui-Na, it can cause muscle soreness for few day as a processing of treatment.

Burns or scarring, blisters are a potential risk of when treatment involves the use of heat lamp or infra-red and may last a few days or sometimes/rarely over 1-6months.

A patient may have an allergic reaction after receiving an acupuncture treatment with sterile needles. Some of the allergic reactions may be in the form of itchiness, rash, swelling, infection, and small purulence. Unusual risks of acupuncture include 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 are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large dosages. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are: nausea, gas, stomachaches, vomiting, liver or kidney damage, headache, diarrhea, rash, hives and tingling sensation of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I understand that the provider will explain all known risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment. 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.

PATIENT SIGNATURE (Or Representative) Month Day Year

_____ Date:_____/_____/_____

CIRCLE ACUPUNCTURE
PAIN & STRESS TREATMENT

Notice of Privacy Practices

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 and sign. This will become part of your medical record.

TREATMENT. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory test and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.
PAYMENT. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.
HEALTH CARE OPERATIONS. Your health information may be used as necessary to support the day-to-day activities and management of Circle Acupuncture.
LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.
PUBLIC HEALTH REPORTING. Your health information may be disclosed to public health agencies as required by law.

Other uses and disclosures require your authorization. Disclosure of you health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before your notified us in writing of your decision.

Your information may also be used to remind you of your appointments, to send you information about your treatment/condition, services that may be of interest of your condition, and public relations or sales related information.

 You have certain rights under the federal privacy standards, These include:
 The right to request restrictions on the use and disclosure of your protected health information.
 The right to receive confidential communications concerning your medical condition and treatment.
 The right to inspect and copy your protected health information.
 The right to receive an accounting of how and to whom your protected health information has been disclosed.
 The right to receive a printed copy of this notice.

We at Circle Acupuncture are required to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices as outlined. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

As permitted by federal regulations, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records or submit a complaint about our privacy policies. If you believe that your privacy rights have been violated, you should call the matter to our attention at the above address.

Your protected health information will be used by Circle Acupuncture or disclosed to others for the purposed of treatment , obtaining payment, or supporting the day-to-day health care operations of the practice. You may request a restriction on the use or disclosure of your protected health information. If Circle Acupuncture agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. Circle Acupuncture reserves the right to modify the privacy practices outlined in the notice.I have reviewed this consent form and give permission to Circle Acupuncture to use and disclosure my health information in accordance with it.

_____ _____

Signature of Patient Date of Signature

CIRCLE ACUPUNCTURE
PAIN & STRESS TREATMENT

Financial Policy

Dear Patient;

We hope that you understand that our credit and collection policies are a necessary part of our practice to provide health care services for all of our patients. Therefore, as a service to you, we will gladly submit charges to your primary insurance company with each visit if you provide us with complete accurate information. Co-payments and deductibles are due at the time of service. If we do not participate in any program with your insurance carrier or third party administrator you must pay the total balance of the visit at the time of service. It is your responsibility to make sure we are a provider with your insurance. If we do participate with your insurance we will file a claim to them and bill you for the amount they deem as your responsibility. You will have thirty days to pay the remaining balance.

It has been our experience that submission of one claim is sufficient to generate payment. However, there are times that we must resubmit a claim. We make every effort to re-file all claims in a timely manner. To assist us in receiving payment from your insurance please call us if you do not receive a statement from your insurance company within eight weeks from the date of service to let us know to file again. Also, call us after you receive a statement from your primary insurance carrier saying they paid us, let us know to file your secondary insurance. WE DO NOT AUTOMATICALLY FILE THE SECONDARY. YOU MUST LET US KNOW. The Secondary will not pay until the primary has paid. Therefore, we cannot file them at the same time.

It is your responsibility to be familiar with your insurance policy. Please let us know when you make your appointment if your policy requires special authorization and inform us of any and all changes in your insurance, address, & phone number at each visit. Failure to do so will result in your full responsibility for payment of services. We will do all we can to obtain the proper authorizations or referrals if we know they are required.

We accept cash, checks, visa, mastercard discover and american express. If unusual circumstances should make it impossible for you to meet our credit terms or if you have questions about your account, we encourage you to call us and discuss the matter. This will help keep your account in good standing. Delinquent accounts may be referred to an outside collection agency for collection and could affect your credit rating.

If you have a worker's compensation injury, we will need the name of the person in charge of all insurance claims for your company, a case number and insurance carrier name and address prior to your visit. The visit must be approved by the worker's compensation supervisor at your place of employment before the visit.

Our office can bill for personal injury cases such as automobile accidents or liability cases. Please provide us with complete accurate information. If we do not receive authorization, you will be responsible for payment in full at the time of service when seen in our office.

If you are unable to keep your appointment, please give at least 24 hours notice of cancellation. Thank you for your cooperation. We are glad you have chosen Circle Acupuncture. Please let us know if we can better serve you.

I have read, understand and agree to the above financial policy for payment of services rendered. I understand that I am ultimately responsible for all professional fees and there is a $25.00 fee for returned checks.

Signature:_____ Date:_____