

NEW PATIENT REGISTRATION FORM - VETERAN

Name: _____ Date of Birth: _____ SSN: _____

Sex: M F Transgender Marital Status: Single Married Widowed Partnered

Address: _____

Phone: _____ Cell Landline Email: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

How did you year about us? _____

REASON FOR BEING SEEN

Reason(s) for being seen _____

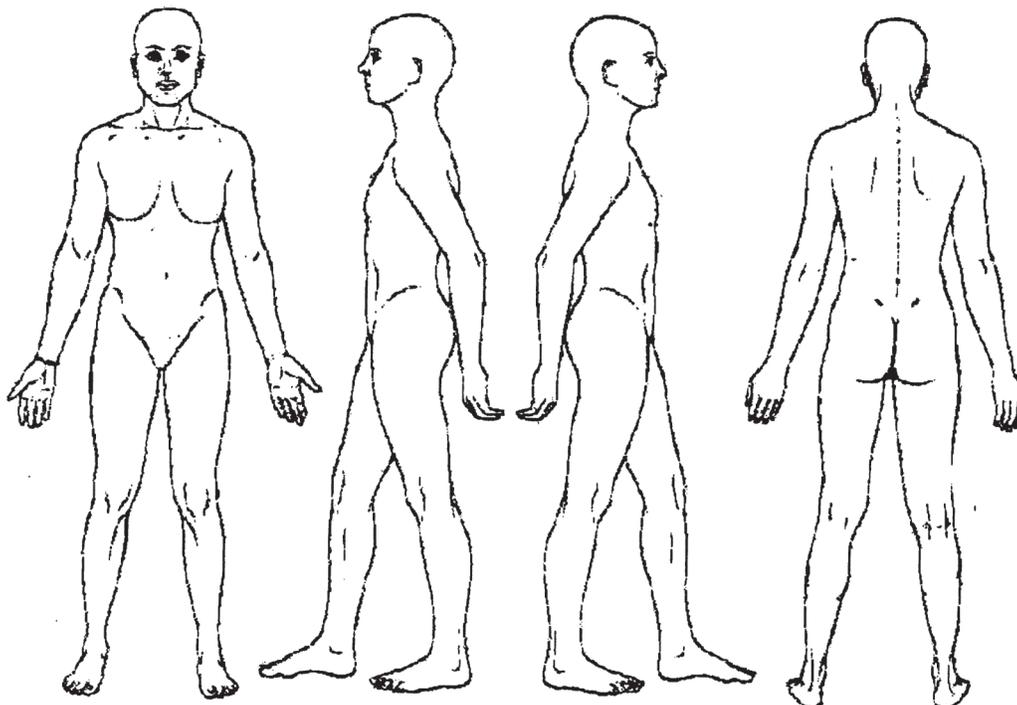
How long have you had this condition? _____ Date of injury (if known) _____

Have you had any tests such as x-ray, MRI, etc., for this condition? Yes No Estimated Date: _____

Have you been hospitalized or gone to an ER because of this condition? Yes No Date: _____

Is this condition service-connected? Yes No Slip & fall, auto, or workplace accident? Yes No

HERE FOR A PAIN CONDITION? SHOW US WHERE IT HURTS



ACUPUNCTURE & CUPPING SERVICES SCREENING

Please inform your provider verbally prior to receiving services if you have any of the following:

- Metal allergy: Nickel, surgical steel or gold, etc.
- Allergies to nuts, peppermint, coconut, herbs or other substances that may be in massage oil
- Fear of needles or history of fainting due to needles (blood draw, injection, etc.)
- Take blood thinners (Coumadin, fish oils, aspirin, etc.) or have a clotting or bleeding disorder
- Difficulty feeling hot, cold, pain or pressure. Location(s): _____

X	ALLERGIES	ALLERGEN	REACTION
	Latex (gloves)		
	Adhesive (bandages, tape)		
	Shellfish (oysters, shrimp, etc.)		
	Antiseptics/Disinfectants (rubbing alcohol, iodine, etc.)		
	Nuts, herbs, plants, mushrooms		
	Any vitamins or supplements? (fish oil, vitamin C, etc.)		
	Other foods including corn, gluten, dairy, fruits, eggs, etc.		
	Other (list all. Use reverse side of form if necessary)		

MEDICATION/SUPPLEMENTS/HERBS (Use reverse side if necessary)	DOSAGE	REASON FOR TAKING

HOSPITALIZATIONS, INJURIES, SURGERIES & MAJOR ILLNESSES & DISEASES (cancer, autoimmune disorders, etc.)	DATE/YEAR	DETAILS (Use reverse side if necessary)

FAMILY HISTORY

Relation	Age	State of health (good, fair, poor, deceased)	Cause of death & age at death	Diseases (diabetes, cancer, lung, heart, kidney disease, etc.)
Mother				
Father				
Brother(s)				
Sister(s)				

COMPREHENSIVE PERSONAL HEALTH QUESTIONNAIRE

GENERAL HEALTH

- Diabetes
- Seizure disorder
- Current cancer
- Past cancer(s)
- Neurological disorder
- Headaches ___Migraines
- Night sweats
- ___Overheated ___Cold easily
- Hot flash (men or women)
- Fertility issues
- Painful/irregular menstrual cycles
- Anemia (Iron/B12)
- Unexplained fatigue
- Hernias
- Appetite changes
- Weight loss/gain

MOOD, EMOTIONS

- High stress
- Depression
- Suicide attempts
- Current or recent thoughts of suicide
- Anxiety ___Panic attacks
- Irritability ___Moodiness
- Anger outbursts
- PTSD
- Dream-disturbed sleep
- Forgetfulness
- Difficulty concentrating
- History or alcohol or drug abuse or addiction
- Current alcohol or drug abuse or addiction

GENITO-URINARY

- Frequent urination
- Painful urination
- Poor bladder control
- Painful urination
- Frequent UTI or Yeast

MUSCULOSKELETAL

- Arthritis
- Neck pain
- Back pain
- Herniated or bulging discs: ___Neck ___Back Which vertebra? _____

- infections
- Blood in urine
- Prostate problems
- Erectile dysfunction
- Penile implants

SLEEP

- Sleep apnea
- Insomnia (just can't sleep)
- I need a sleep aid to sleep
- Mind won't shut down at night
- Pain interferes with sleep
- Can fall asleep but have trouble staying asleep
- Restless sleeper
- Dream-disturbed sleep

GASTROINTESTINAL

- Constipation
- Diarrhea
- Bloating
- Noisy gut
- Gas/flatulence
- Hemorrhoids
- Heartburn/Reflux/GERD
- Belching
- Bloody stools
- Nausea ___Vomiting
- Stomach pain
- Peptic Ulcers

CARDIOVASCULAR

- Heart disease/condition
- Chest pain/heaviness
- Shortness of breath
- Dizziness w/positional changes (rising from sitting, etc.)
- Random dizzy spells
- Other dizziness
- Fainting/syncope
- HIGH/LOW blood pressure
- Irregular heartbeat
- RAPID/SLOW heart rate

- Cardiac disease
- Pacemaker/implant
- Poor circulation
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Tinnitus (ringing in ears)
- Earaches/infections
- Ear discharge
- Hearing loss
- Vision loss or changes
- Eye disease/disorders
- Floaters
- Cataracts
- Red eyes
- Dry eyes
- Difficulty swallowing
- Swollen glands
- Tonsil problems
- Lump in throat sensation
- Phlegmy (nose, throat clearing, etc.)
- Frequent sore throat
- Sinus problems
- Allergies (food, pollen, etc.)

HAIR, SKIN, NAILS

- Dry or brittle hair
- Hair loss
- Brittle or peeling nails
- Dry skin
- Bruise easily
- Rashes
- Hives
- Itching
- Scars
- Boils
- Cystic acne
- Mole changes
- Slow healing sores/infections

- Shoulder problems
- Muscle cramps, spasms or twitches
- Generalized muscle aches
- Numbness/tingling

Health & Wellness

Smoking/ Tobacco Use: Current Past Never Type: Smoke/Vape/Chew/Patch/Gum Amount/day: _____ # of Years: _____

Alcohol: Current Past Never Socially Daily One or more times per week

Recreational drug use (Rx or street drugs): Current Past Never Type: _____

Current Living Situation (Check all that apply): Live alone Married ___with ___without children Multi-generational Household
 Homeless Shelter Other:

How often do you get the social and emotional support you need? Always Usually Sometimes Rarely Never

How often do you communicate with friends or relatives outside the home? Often Occasionally Rarely Never

Are there any cultural or religious concerns you have related to our delivery of care? Yes No

OFFICE POLICIES

Medical Records Release Should you need copies of your records or other documents including receipts and income tax-related documentation, please note the following in accordance with Florida Statutes, and is payable prior to receiving the copies. For copies of records, or reports, a minimum of ten (10) working days and not more than thirty (30) may be required to process your request. A completed and signed record release must be done before any records are released.

Forms & Reports There will be a \$25-\$150 administrative fee for forms such as disability reports and letters of medical necessity (does not apply to routine reports requested by the VA). The fee will be determined based on the complexity of the document. Please allow seven (7) to twenty (20) days for these reports to be completed. We do not fill out disability forms at this facility.

Policy Regarding Minors. We love children at East Lake Acupuncture; however, due to safety and noise issues we ask that all children be left at home. For safety reasons children are prohibited from waiting in a treatment room while parents/guardians receive treatment, and cannot be left unattended in the lobby, and cannot be left with a "babysitter". Staff are prohibited from babysitting/watching children.

Family & Friends. With the exception of a parent accompanying a minor receiving treatment or a caretaker accompanying a disabled individual whom requires their presence in the treatment room, or requires a translator, family and friends are asked to wait offsite whenever possible. Our lobby is very small. Seating is reserved for patients.

No cell phone use. This a place of calm and quiet. Cell phone use is prohibited. Please step outside if you need to make or take a call. Phone use during treatment is prohibited for safety and noise purposes. Please use headphones if watching videos or listening to your own music.

Refunds. Refunds on products will only be offered if they are returned within fourteen (14) days of the date of purchase and are unopened, with the seal still intact. There are no refunds on services rendered, injections given, or opened products for any reason. There are no refunds or exchanges on rendered services or procedures, including injections.

No-Show/Late Cancellation Policy (does not apply to VA patients) If an appointment is missed or not cancelled with 24-hours prior notice to the scheduled time, a fee of \$30.00 for acupuncture and medical services. The full price of the service will be charged for massage therapy. All "no-show" or "late cancellation" fees are to be paid in full on or before the next visit. Insurance will not reimburse the patient for this charge, nor will we bill the insurance for the visit. Our office staff makes appointment confirmation by text as courtesy, though it is the patient's responsibility to remember his/her appointment date and time.

Non-Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, sexual orientation, nationality, political affiliation, disability, or age. All patients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964. Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Insurance: As a courtesy, we will do our best to pre-verify your coverage and bill your insurance for the services provided during your visit(s); however, it is your responsibility to know your policy benefits and limitations. Our billing agent is available to answer questions you may have regarding our billing procedures. Please be aware that costs for each session may vary, depending on procedures performed.

Uninsured discounts. We recognize the significant financial burden medical expenses create for patients with limited or no healthcare coverage. We will offer uninsured patients a similar discount to the discount taken by our contracted insurance carriers. Please see our posted fee schedule, as fees are subject to change from time-to-time without notice.

Collections: In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Billing and Collections Policy, East Lake Acupuncture may engage in collection activities—including extraordinary collection actions (ECAs)—to collect outstanding patient balances. Patients or their responsible parties are expected to pay their full liability for services rendered within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan. In the event the account becomes delinquent and is turned over to a collection agency, there will be a \$50.00 fee for each account and that you are responsible for, as well as any actual collection, court, or attorney fees.

Responsibility for Personal Valuables: We do not provide facilities for safekeeping of valuables and are not responsible for lost, stolen or damaged personal items that you or anyone accompanying you may bring into the facility. Please monitor your belongings and be sure to take your belongings with you when you leave.

I, _____, have read the above policies and understand my rights and agree to abide by said policies.

Printed Name

Signature

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & OFFICE POLICIES

Privacy Policy. All records are kept strictly confidential and are subject to HIPAA compliance and will not be shared with any outside establishment, individual, organization or medical facilities without explicit written consent from the client (you) or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons or other court order.

Copies of our detailed Privacy Policy are available upon request, on our website (www.eastlakacu.com) and are posted near the front desk and are on the clipboards containing the new patient paperwork. You may request a copy via email by emailing us at info@eastlakeacu.com.

By my signature below, I certify that I been given the opportunity to review and request a copy of East Lake Acupuncture, LLC's Notice of Privacy Practices and Office Policies (posted in the reception area & on intake clipboards) on the date indicated below.

Printed Name

Signature

Date

FINANCIAL AGREEMENT & ASSIGNMENT OF BENEFITS

Request for Services: I have requested medical services from East Lake Acupuncture, LLC (ELA) on behalf of myself and/or my dependent, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized (does not apply to VA authorized services). I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon receipt of a. A photocopy of this assignment is to be considered as valid as the original.

I understand that the quote of benefits Provider receives from my insurance carrier at the time of verification and/or of service, are not a guarantee of coverage and that Provider does not have control over benefits or coverage. I understand and acknowledge that as the patient, legal guardian or parent (if the patient is under 18 years old) I will be responsible for the co-payment, co-insurance any deductible at the time of service.

Veteran's Affairs & Worker's Compensation. Charges related to Veteran's Affairs or Workers Compensation, or injury shall be forwarded to the appropriate entity, and I will not be held personally responsible for these charges. I understand that if I claim Worker's Compensation benefits and those benefits are subsequently denied, I may be held responsible for the total amount of charges for services rendered. I understand that an authorization from the VA must be received prior to receiving services, in order for the VA to pay the claims. Treatment outside of an authorization is my financial responsibility, or that of any other insurance I might have, and which provides coverage for services rendered.

Authorization to Release Information. I hereby authorize ELA to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime; (4) initiate a complaint to the VH/VHA, insurance carrier and/or Insurance Commissioner for any reason on my behalf should the provider feel there is a valid reason for doing so. This order will remain in effect until revoked by me in writing.

Authorization. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, and/or the VA/VHA/Optum/TriWest, etc., directly to ELA. I hereby authorize that photocopy of this form to be valid as the original. I hereby assign my rights to payment to my provider, and I certify to the best of my knowledge that: I (or my dependent) received or intend to receive services from East Lake Acupuncture, LLC and I want East Lake Acupuncture/Provider to seek payment for services rendered, from my insurance carrier. I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Financial Responsibility. I agree to make full payment immediately upon receipt of an ELA billing statement whether it is an interim or final bill. I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service or immediately upon receiving a bill for a balance due. I understand that I am responsible for all fees and charges related to all services and durable goods provided to me through ELA and its providers from my first date of examination or treatment forward, as well as any balance due after payment by my insurance company. **Does not apply to VA or Worker's Comp authorized services.**

Remittance. I request that my insurance carrier, and/or the VA/VHA, make payment directly to the treating physician or to provider, East Lake Acupuncture, for all services rendered at this facility. If my current policy prohibits direct payment to Provider, I instruct and direct my insurance carrier to make the check out in my name but send the check to Provider, not to me (or my dependents). Additionally, if my insurance carrier makes payments to me, I agree to immediately sign over/pay over these funds to Provider. I also authorize Provider, to deposit any check(s) made out to me and bearing my endorsement. I understand and agree that if I fail to turn over funds paid to me by my insurance company, for which I am responsible, within thirty (30) days, I am responsible for a \$50 processing fee as well as the actual costs of collecting monies owed, including court costs, collection agency fees and attorney fees. Does not apply to VA/VHA authorized services.

Collections & Legal Fees. I understand that if for any reason my insurance company does not pay my bill within 90-days, I will be fully responsible for payment. I also acknowledge that it is my responsibility to fully understand the rules and regulations of my insurance company as well as the details of coverage including any restrictions.

I, _____, have read the above policies and understand my rights and agree to abide by said policies.

Printed Name

Signature

Date

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine, and/or CAM (complementary and alternative medicine) procedures on me (or on the patient named below, for whom I am legally responsible) by a licensed healthcare provider, acting within his/her scope of practice and licensure parameters.

I understand the methods of treatment may include but are not limited to, acupuncture, moxibustion, cupping, gua sha, electrical stimulation, Tui Na (Chinese Massage), manual therapies (myofascial and trigger point release, massage therapy, physical and rehabilitative medicine modalities, food therapy, nutritional and lifestyle counseling, injections of herbs, natural substances, vitamins and minerals, bloodletting, and Chinese herbal medicine. I have been given the opportunity to discuss the nature and purpose of my treatment, my treatment plan, and other procedures, contraindications and side effects with my provider and have been given handouts providing additional written materials containing details of various procedures.

Acupuncture, injections and bloodletting. Acupuncture is generally considered a safe method of treatment, but that it may have side effects, including, but not limited to bruising, redness, swelling, itching, or numbness or tingling near the needling sites that may last a few days, with possible dizziness or fainting. Rare and unusual risks of acupuncture may include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax) may occur with deep needling or injections. Like acupuncture, injections (trigger point, acupoint, intramuscular, or subcutaneous) and bloodletting could cause pain, post procedure soreness, bruising, bleeding and/or an infection at the site. I understand that the risk of infection is negligible when all needles are sterile, but anytime the skin is punctured or broken, there is the potential for infection. At East Lake Acupuncture we are mindful of underlying structures and organs and practice Clean Needle Technique without exception. While we do occasionally administer intramuscular injections, we typically form wheals (little fluid-filled "bumps" just under the skin) and avoid needling or injecting deep enough to cause organ damage or puncture, thereby creating an even safer experience. Bloodletting involves pricking the skin over a blood vessel using a sterile lancet or hypodermic needle. We do not prick arteries, varicose veins, or large distended veins.

Cupping and gua sha. I understand that cupping and gua sha therapies will leave bruise-like ("hickey") marks that will last several days to several weeks to fully clear. These areas of bruising or discoloration are typically not painful, though there may be soreness at the site(s) and in the surrounding muscles. Itching during and immediately following cupping or gua sha is typical due to the stretching of the skin and fascia and opening of pores. Cupping and gua sha are medical procedures, not a novelty and should be treated accordingly. Your provider will determine which areas are most appropriate for treatment, which type techniques or methods should be used, and where how treatment should be applied, the length of time the cups should remain on, and which cupping techniques (stationary, moving, etc.) or gua sha techniques to employ. These are not services in which the patient should expect to dictate the terms of the service such as in a massage service. On rare occasions burns or blisters may occur with "fire cupping" which involved using open flame to remove oxygen from glass cups. Blisters can occur both from the heat and from fluids being drawn to the surface by non-heated cups, and the presence of a blister is not necessarily an indication of a burn. Small blisters should be left alone to heal on their own, while larger blister should be drained and dressed by the provider. In severe cases, you may be referred to an emergency room. Cupping treatments may be a "detoxifying" treatment process and as a result, some patients may feel nauseous or unwell following treatment. Drinking water and taking Vitamin C has been reported to quickly relieve the discomfort. Be sure to inform your provider prior to receiving cupping if you have difficulty feeling pain, hot, cold or pressure. It is important that your provider be aware.

Herbs and supplements. The herbs and nutritional supplements (which are from plant, animal and mineral sources and may contain tree nuts, shellfish and other allergens) that may be recommended are generally considered safe, although some may be toxic in large doses, or interact with medication. I understand that some herbs or supplements may be inappropriate during pregnancy, while nursing, or while on blood thinners. Some possible side effects of taking herbs include allergic reactions, nausea, gas, stomachache, vomiting, diarrhea, rashes, hives and tingling of the tongue. Herbs and supplements need to be consumed according to the instructions provided orally and/or in writing. The herbs may have an unpleasant smell or taste. I understand that some herbs or supplements could interact with other things I am taking, including medications, and I have been advised to check ingredients before consuming, using reputable, printed or online resources including, but not limited to: <http://healthlibrary.brighamandwomens.org/Library/DrugReference/DrugInteraction/>, <https://www.aafp.org/afp/2017/0715/p101.html>, <https://healthy.kaiserpermanente.org/health-wellness/natural-medicines> (there are a number of reputable sources available online).

Side effects. I will immediately inform my provider of any unanticipated or unpleasant effects associated with the treatment or of the consumption of herbs and/or supplements. I will notify my provider if I am, or become pregnant. I do not expect the provider(s) to be able to anticipate and explain all possible risks and complications, and I wish to rely on the provider(s) to exercise judgment during the course of the procedure which the provider believes, based on the facts then known, is in my best interests.

I have read, or have read to me, the above consent. I have also had the 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. I have been provided with a copy of the handout, What to Expect Your First Visit, and made aware that additional information in the form of handouts and therapy-specific informed consent forms, wall posters, lobby brochures, and in blog articles and online at www.eastlakeacu.com.

Patient's Printed Name _____ Date of Birth: _____

Patient's Signature (or guardian) _____ Date Signed _____