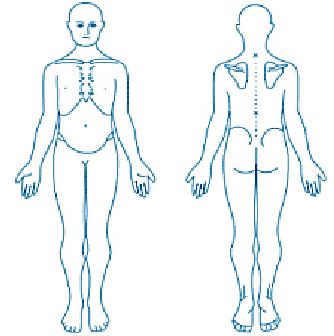
New Patient Intake Form

First Name_____________________________ **MI**__________ **Last Name**___________________ **Date:**_________________
Date of Birth:______________________ **Age:**__________ **Email:** ____
Address:____ **City, State, Zip** _____________________________________
Home Phone #: _______________________ **Work:** __________________________ **Cell:** ______________________________
Occupation: _______________________________ **Please check here if we can email you updates and a newsletter.** _____

Marital Status: ☐ **M** ☐ **S** ☐ **W** ☐ **D** **Height:** ________ **Weight:** ________ **Allergies:** ____________________
Emergency Contact Name:_________________________ **Phone:**___________________ **Relationship:**_________________
Physician: (Name) ____ **(Phone)** ______________________________

General Questions:

PLEASE MARK YOUR AREA OF PAIN



Have you had acupuncture before? ☐Yes ☐ No
Chief Complaint: ____
How long have you had this condition?____
Is it getting worse? ☐Yes ☐No **Does it bother your:** ☐Sleep ☐Work ☐Other ___________
What seemed to be the initial cause? ____
What seems to make it better? ____
What seems to make it worse? ____
Are you experiencing pain right now? ☐Yes ☐ No
Describe your pain: ☐Dull ☐Sharp ☐Stabbing ☐Shooting ☐Burning ☐Other__________
What makes your pain better? ☐Heat ☐Pressure ☐Movement ☐Cold ☐Massage ☐ Rest

Family Medical History:

☐Arteriosclerosis ☐Cancer ☐Diabetes ☐Seizures ☐Asthma ☐Heart Disease ☐Stroke
☐Alcoholism ☐High Blood Pressure ☐Other: ____

Are you currently on any medications? ☐No ☐Yes If Yes, Please List: _______________________________
Do you take any vitamins/supplements? ☐No ☐Yes If Yes, Please List: ______________________________

Lifestyle:

☐Alcohol # per day____________ ☐Stress ☐Marijuana ☐Regular Exercise:
Type _____________ Frequency____________
Type _____________ Frequency____________
☐Tobacco # per day____________ ☐Drugs ☐Occupational Hazards

Your Past Medical History: (Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

☐ AIDs/HIV	☐ Diabetes	☐ Measles	☐ Thyroid Disorders	☐ Major Trauma:
☐ Alcoholism	☐ Emphysema	☐ Mumps	☐ Tuberculosis	____________________
☐ Allergies	☐ Epilepsy	☐ Pacemaker	☐ Thyroid Fever	____________________
☐ Appendicitis	☐ Goiter	☐ Pneumonia	☐ Ulcers	____________________
☐ Arteriosclerosis	☐ Gout	☐ Polio	☐ Venereal Disease	____________________
☐ Asthma	☐ Heart Disease	☐ Rheumatic Fever	☐ Whooping Cough	☐ Other: ____________________
☐ Birth Trauma (your own birth)	☐ High Blood Pressure	☐ Scarlet Fever	☐ Surgery (Please List All) ____________________	____________________ ____________________
☐ Cancer	☐ Herpes	☐ Seizures	____________________	____________________
☐ Chicken Pox	☐ Hepatitis	☐ Stroke		

General Symptoms: (Please check all that apply)

☐Poor appetite	☐Heavy appetite	☐Craves cold drinks	☐Craves hot drinks	☐Bleed or bruise easily
☐Chills	☐Cold hands or feet	☐Poor circulation	☐Night sweats	☐Sweat easily(describe): ____________ ____________
☐Dream-Disturbed Sleep	☐Insomnia	☐Heavy Sleep	☐Anxiety ☐Depression	☐ Facial pain
☐Fatigue	☐Vertigo or dizziness	☐Blurred vision	☐Recent weight loss/gain	☐Poor Memory
☐Fever	☐Glaucoma	☐Sinus problems	☐Eczema ☐Hives	☐Easily Stressed ☐Hair Loss
☐Asthma/wheezing	☐Nose bleeds	☐Headaches	☐Migraines	☐Change in hair/skin texture
☐Difficulty breathing when lying down	☐Shortness of breath	☐Tight Chest	☐Numbness	☐Chest Pain
☐Cough: If yes, is it ☐Wet OR ☐Dry ☐Thick OR ☐Thin	☐Coughing Blood ☐Tachycardia ☐Fainting	☐Pneumonia ☐Blood clots ☐Seizures	☐High blood pressure ☐Irregular Heartbeat	☐Low blood pressure ☐Heart Palpitations ☐Difficulty Breathing
☐Diarrhea	☐Constipation	☐Intestinal Pain	☐Bloody Stools	☐Bowel Movements: Frequency per day ____________
☐Nausea	☐Acid regurgitation	☐Vomiting		
☐Pain on urination	☐Blood in urine	☐Frequent urination	☐Impotence	
☐Considered/attempted Suicide	☐Lymph Nodes Removed	☐Infectious Diseases: ____________ ____________		

Musculoskeletal: (Please check all that apply)

☐Neck/shoulder pain	☐Upper Back Pain	☐Joint Pain	☐Limited Range of Motion	☐Other: ____________
☐Muscle pain	☐Low Back Pain	☐Rib Pain	☐Muscle Spasm	____________

Woman Only: Gynecology

Are you pregnant? ☐Yes ☐No	Duration of flow ____________	☐Irregular Periods	☐Painful Periods	☐PMS
Vaginal Discharge (Color) ____________	☐Vaginal Sores	☐Vaginal Odor	☐Clots	Date Last Period began ____________
Length of cycle (Day 1 to Day 1) ____________	# Pregnancies ____________	# Live Births ____________	Premature Births ____________	Age at Menopause ____________

Please List Any Other Pertinent Information:

____

____

____

____

I have read and agree to the Financial Policies of Acupuncture Family Healthcare Clinic, PC.

Signature of Patient______________________________ **Date**____________________

FINANCIAL POLICY

Welcome to Acupuncture Family HealthCare Clinic, PC. We strive to provide our patients with the highest quality medical care. In an effort to foster a collaborative relationship, we ask that you review our updated financial policy so that you understand your responsibilities in this relationship. Our goal is to provide and maintain an excellent physician-patient relationship. Letting you know our office policy in advance allows for an effective flow of communication and enables us to achieve our goal. If you have any questions, please do not hesitate to ask a member of our staff. Acupuncture Family HealthCare Clinic (www.AcuFHCC.org) reserves the right to make changes to this policy as needs arise. For the most updated policy, please refer to this website.

General Policies

1. On each arrival, please check in at the front desk and present your current insurance card and photo ID. If you are new to the practice, **or if your insurance or demographic data has changed**, you will be asked to fill out our registration paperwork. These forms for registration are also available online and can be downloaded and completed prior to your visit. This is your verification of the correct insurance and consent to bill them on your behalf. ***If the insurance company or information that you designate is incorrect, you will be responsible for payment of the visit.***
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. **Co-pays are due at the time of the visit**.
3. While the filing of insurance claims is a courtesy that we extend to our patients, **all charges not covered by your insurance company are your responsibility**. Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for any reason, except where prohibited by law or prior contractual agreement.
4. Patient balances are billed immediately upon receipt from your insurance plan's explanation of benefits. We request that you pay your outstanding balance *within 10 business days* of your receipt of your bill.
5. If you have personal financial problems, a monthly payment plan may be arranged. Please call our billing department and speak to one of our billing personnel. If an account is referred for collection, extra charges will be assessed
6. If our physicians do not participate in your insurance plan, payment in full is expected at the time of your office visit.

7. If you do not have health insurance, payment for an office visit is due at the time of the visit.
8. Health insurance is a contract between you, your employer, and your insurance company. It is your responsibility to be familiar with the specifics of your insurance policy and coverage.
9. Not all services provided by our office are covered by every plan. Medical care and treatment are dictated solely by medical necessity and is not based on medical insurance coverage. Any service not covered by your plan will be your responsibility. Acupuncture Family HealthCare Clinic accepts payments through personal checks, VISA, MasterCard, and Discover cards.
10. For patient convenience, Acupuncture Family HealthCare Clinic offers a service to securely hold the last four digits of your credit card through Tebra, a billing company. Please see the attached form for your signature.

Appointments

1. We require a deposit of **$125.00** (**50%** of the first initial visit fee) for **all out of network new patients** to secure your future appointment, shall you decide to cancel the appointment 24 hours ahead of your appointment time, the deposit will be fully refunded to the original payment method. If you do not show up for your scheduled appointment and do not call to cancel your appointment without 24-hour notice, your deposit will **NOT** be refunded.

2. If you are late for an appointment, we will do our best to accommodate you. However, it may be necessary to reschedule your appointment to a later time or, if non-urgent, to another day.

3. Missed and canceled appointments represent a cost to us, to you, and to other patients of our practice who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. For cancellations, a 24-hour notice prior to the appointment is required. Failure to cancel with notice will result in a **$50.00** missed appointment charge. Multiple missed appointments may result in dismissal from the practice.

4. We will not schedule further routine appointments if your account is turned over to a collection agency or if you default on a payment plan.

5. We strive to minimize wait time. However, emergencies and unexpected prolonged visits do occur and will take priority over a scheduled visit. We appreciate your patience and understanding.

6. As a courtesy, we can either email or text to remind parents about their appointments. If we are unable to reach you, the ultimate responsibility to remember the appointment is yours. You will be responsible for a missed appointment charge if an appointment is missed.

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process, except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, as to whether this agreement is unconscionable, and any procedural disputes, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. ________. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

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

OFFICE SIGNATURE **X** (Date)

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ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE

ACUPUNCTURE INFORMED CONSENT TO TREAT

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 have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including 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 spontaneous 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 (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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed.

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.

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.

ACUPUNCTURIST NAME:

(Date)

PATIENT SIGNATURE **X**

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

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

Advanced Notification Form
Out-of-Network Patients

ACUPUNCTURE FAMILY HEALTH CLINIC
2655 First St Suite 345 • Simi Valley, CA 93065
TEL: (805) 864-9290 • FAX: (805) 864-9291 •
info@acufhcc.org

Dr. Gerie Keh, DAOM, LAc., feels fortunate to have the opportunity to render healthcare services that have significant positive impacts on her patients. However, **Dr. Keh is an out-of-network provider** for insurance companies.

However, her patients can request superbills to submit to their insurance company for possible reimbursement. The process depends on patients' out of network coverage. The clinic is **NOT** responsible for the submission outcome. If you are in agreement with the above, please carefully read, complete and sign this advanced notification form as it appears below.

Should you have any questions regarding services from an out-of-network provider, please contact your insurance company for more information prior to completing this notification form.

TO BE COMPLETED BY THE PATIENT OR PATIENT'S LEGAL GUARDIAN

I, ____, do hereby acknowledge the following:

1. I have been informed that Dr. Gerie Keh does not participate with my insurance discounts or write-offs.
2. I know that I may be responsible for additional costs for all services provided by Dr. Keh.
3. I was given an opportunity to contact my insurance company before obtaining services rendered by Dr. Keh to confirm my benefits for the services she renders.
4. Furthermore, I had the choice to obtain names of participating facilities and/or participating providers that can provide the recommended services Dr. Keh provides.
5. I understand that Dr. Keh is prohibited from waiving co-payments, deductibles, coinsurance, or other member cost sharing amounts.
6. I hereby, on behalf of myself or my child(ren), voluntarily choose to obtain the services or procedures rendered by Dr. Gerie Keh, DAOM, LAc.

APPROVALS

____ ____________________
Signature of Patient, Parent, or legal guardian (if patient is a minor) Date

____ ____________________
Printed Name of Patient, Parent, or legal guardian (if patient is a minor) Date

HIPAA Acknowledgment and Consent Form

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

You may be contacted via email and/or text messaging to remind you of an appointment and/ or to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

______ (initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is (include area code) ______________________________.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is____.

Acupuncture Family Health Care Clinic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (Print Clearly)____

Patient Signature _________________________________ Date __________________________

Revocation: ***I hereby revoke my request for future communications via email and/or text.***

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: ____

Patient/Patient Representative Signature: ____

Date: _____________________________ *Time:* ____________________

Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes **Acupuncture Family Healthcare Clinic** to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Patient's Name: ____

Name as it Appears
on the Credit Card: ____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐ ☐ ☐ ☐

Expiration Date: ____________________

I, ____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

______________________________________ ______________________

Cardholder's Signature Date

kareo
Go Practice