CONFIDENTIAL

New Patient Intake Form

Last Name _____First_____Middle_____

Sex: □ Male □ Female □ Other Date of Birth _____Age _____

Primary Phone (_____) _____ Alternate Phone (_____) _____

Address _____

Email _____

Referred by □ internet □ health care provider □ family/ friend _____

EMERGENCY/GUARDIAN CONTACT INFORMATION

Contact Name: _____ Phone (_____)_____

METHOD OF PAYMENT and FINANCIAL POLICY Check which box applies

□ Out-of-pocket Cash/Credit/Debit: New Patients $120, Return Patients $80
Packages available after initial treatment.

□ HSA/FSA: Payment is due at the time of service. A superbill receipt for all FSA/HSA cards is available by request. New Patients $120, Return Patients $80.

□ Kaiser Referral: Before you schedule with a Kaiser policy you must have a printed referral letter issued by American Specialty Health stating Kaiser Permanente referral for acupuncture services. Copayments will be taken at the front desk each day of service.

You are financially responsible for treatment. Santee Acupuncture is not responsible for any limitations in coverage that may be included in your plan.

Member ID _____

Print Patient's Name: _____

Signature: _____ Date: _____

Last Name _____First_____Middle_____

Height: _____ Weight: _____ lbs Occupation: _____

Relationship Status □ Married □ Single □ Divorced □ Widowed □ Partnered # Children_____

Are you under the care of a physician now? □ Yes □ No
If yes, for what? _____

Physician's Name _____Phone (_____) _____

Have you received Acupuncture before? □ Yes □ No If yes, when?_____

Condition(s) treated _____

How was your experience?_____

Is today's visit Work Injury related? □ Yes □ No If yes, Date of Injury_____
Is today's visit Auto Accident related? □ Yes □ No If yes, Date of Accident _____

List up to two main health concerns/ related symptoms for which you are seeking acupuncture:

Condition 1._____

Date of onset of symptoms _____Severity of Symptoms 1 (mild) - 10 (severe) _____
Prior attempts to correct problems (Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

Condition 2.

_____

Date of onset of symptoms _____Severity of Symptoms 1 (mild) - 10 (severe) _____
Prior attempts to correct problems (Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

What are your goals of treatment?

_____

Last Name _____First_____Middle_____

Check the Box if any of the following statements are true:

☐ I have known Allergies	☐ I am taking Coumadin/Warfarin	☐ History of Seizures
☐ I have a Pacemaker	☐ I am taking Lithium	☐ History of Head Trauma

Prescription drugs you are currently taking:

Drug Name: _____ Condition _____
Drug Name: _____ Condition _____
Drug Name: _____ Condition _____
Drug Name: _____ Condition _____
Drug Name: _____ Condition _____

Vitamins, Supplements, Over-the-Counter Medication you are currently taking:

Name: _____ Condition_____
Name: _____ Condition_____
Name: _____ Condition_____
Name: _____ Condition_____
Name: _____ Condition_____

MEDICAL HISTORY Please list diagnosed medical conditions and indicate S (self) or F (family)

_____

_____

List all past Hospitalizations, Surgeries, and Accidents including dates

_____

_____

Allergies, Food Sensitivities:

_____

PERSONAL LIFESTYLE

Cigarettes (packs/ day) _____ Coffee/Tea/ Soda (cups/ day) _____ Alcohol (drinks/ wk)_____
Recreational Drugs_____
Food cravings_____

INFORMED CONSENT
FOR ACUPUNCTURE & ORIENTAL MEDICINE TREATMENT AND CARE

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 Santee Acupuncture.

I understand that the methods of treatment may include, but are not limited to, acupuncture, acupressure, moxibustion, cupping, electrical stimulation, Tui-na and Chi Nei Tsang (Chinese medical massage), Chinese herbal medicine, lifestyle recommendations, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, and that it may have side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. I understand that I should not move while the needles are being inserted, retained, or removed. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the acupuncturist below uses sterile disposable needles and maintains a clean and safe environment. I will immediately notify the acupuncturist of any unanticipated or unpleasant effects associated with the consumption of the herbs. I will notify the acupuncturist who is caring for me if I am or become pregnant. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment which the acupuncturist thinks at the time, based upon the facts then known, is in my best interest.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I understand that the results are not guaranteed. I understand that the office medical and administrative staff may review my medical records and lab reports, and 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, this consent to treatment, have been told about the risks and benefits of acupuncture, and have had an opportunity to ask questions.

Patient Name _____

Signature_____Date_____

To be completed by the patient's representative if patient is a minor or is physically or legally incapacitated:
Print name of representative_____

Relationship or Authority of Patient_____

Patient Responsibility and Office Policies

Thank you for choosing Santee Acupuncture as your acupuncture healthcare provider. We are committed to providing you quality acupuncture services. Please read the following policies, initial, and sign below in the spaces provided.

Cancellations/No Show Initials: _____

It is the office policy of Santee Acupuncture to require cancellation 24 hours before your scheduled appointment. If you cancel with less than 24 hours notice or fail to attend a scheduled appointment, you will be charged the full value of the appointment.

Running Late Initials: _____

If you are more than 10 minutes late we will need to Cancel and Reschedule (Tardy appointment $40 fee applies). The 3rd tardy appointment and/ or missed appointment will require dismissal from the practice.

Assignment and Release Initials: _____

I authorize the release of medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to Santee Acupuncture.

Receipt of Notice of Privacy Practices Initials: _____

I hereby acknowledge that I have been offered a copy of this office's Notice of Privacy Practices (in office). I further acknowledge that a copy of the current notice will be available by request, and that any amended Notice of Privacy Practices will be available at each appointment.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF THE OFFICE POLICIES DESCRIBED ABOVE.

Print Patient'sName:_____

Patient Signature: _____ Date: _____