Ginkgo Gold
ACUPUNCTURE

New Patient Intake Form

(Please use print-writing)

Personal Information

Name _____ Birth Date _____

Marital Status: _____Gender _____

Address _____City_____State_____Zip_____

Home Phone _____ Cell Phone_____ Email_____

Occupation _____ Employer _____

Emergency Contact: Name _____ Phone _____Relationship _____

Primary Physician: Name_____ Phone _____

Preferred communication method: text/email/call _____ Had acupuncture before? Yes ____ No ____

How did you hear about us/Referred by: 1. Online ( ), 2. Family ( ) _____, 3. Friends ( )_____,
4. Healthcare Providers ( )_____, 5. Other ( )_____

Main Complaints

Reason for a visit today_____

How long have you had this condition? _____

What seemed to be the initial cause? _____

What seems to make it better? _____

What seems to make it worse? _____

Does it bother you: Sleep _____ Work _____ Other _____

Have you been given a diagnosis for these problems? (Y /N), Diagnosis: _____

What treatments have you tried and what were the outcomes? _____

Medical History

Check all the illnesses or conditions which you currently have or have had in the past

- ○ AIDS/HIV
- ○ Asthma
- ○ Cancer
- ○ Chicken Pox
- ○ Diabetes
- ○ Eating disorders
- ○ Epilepsy
- ○ Glaucoma
- ○ Heart Disease
- ○ High Blood Pressure
- ○ Hi Fevers
- ○ Hypothyroid
- ○ Hyperlipidemia
- ○ Jaundice
- ○ Kidney Disease
- ○ Measles
- ○ Meningitis
- ○ Multiple Sclerosis

- ○ Mumps
- ○ Obesity
- ○ Pneumonia
- ○ Rheumatic fever
- ○ Scarlet fevers
- ○ Sexually Transmitted diseases
- ○ Stroke
- ○ Tuberculosis
- ○ Typhoid fever
- ○ vascular disease

other_____?

Do you have bleeding disorders such as hemophilia or use blood thinners such as coumadin, or warfarin? _____

Do you have a pacemaker? _____

Do you currently have any infectious diseases? If yes, please identify: _____

Do you have any allergies? (Y /N) _____ Are you pregnant? _____

The Medication You Are Taking Now:

Drug/ Supplement	Reason For Taking

Visual Analog Scale(pain)

Referring to the drawings below,

1. Please **indicate** where you are experiencing pain by describing the area of injury.

2. The scale **number** for your pain level.

_____

3. What does your pain feel like?

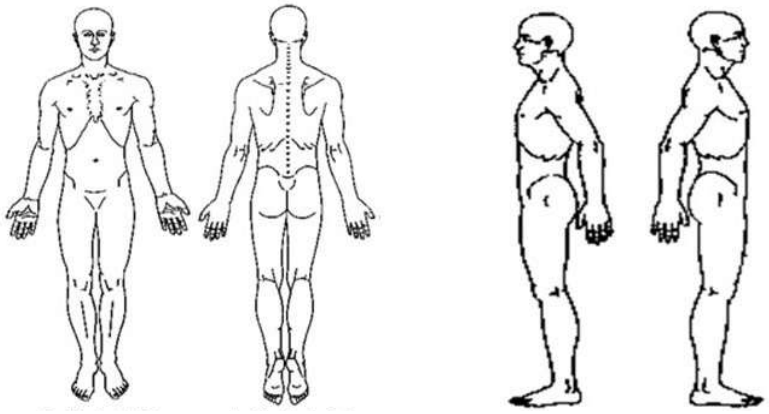
_____

4. Does the pain radiate? Where?

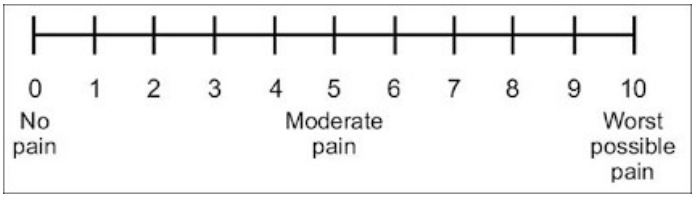
_____

5. How long have you had this pain?

_____



Right / Left Left / Right Left Right



6. What helps to reduce the pain _____

7. What aggravates the pain _____

8. What treatments have you tried for this pain? and what were the outcomes? _____

I certify that the above information is true to my knowledge.

Patient's Signature: _____ **Date:** _____

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Acupuncture Informed Consent to Treat

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that I am under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

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 appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: 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 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. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician. Some possible side effects of taking herbs are: nausea; gas; stomachache; vomiting; liver or kidney damage; headache; diarrhea; rashes; hives; and tingling of the tongue.

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, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). 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.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm 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 agree with the current or future recommendations for care. 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.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Acupuncturist Name: ( )Huang, Xiaoyuan; ( )Faix, Jonathan; ( )Xie, Mingjun (Irene).

Patient Name (Print)	Patient Signature	Date
_____	_____	_____
	(Indicate relationship if signing for patient)	

Ginkgo Gold Acupuncture

The Notice of Privacy Practices (HIPPA) is available for review and/or a copy is provided upon request.

Initial: _____

Ginkgo Gold Acupuncture will NOT be held responsible for loss or damage to personal belongings.

Initial: _____

Billing Policy

- Ginkgo Gold Acupuncture accepts cash, debit/credit cards, does NOT accept checks; all payments are due at the time of the service.
- Ginkgo Gold Acupuncture does NOT bill insurance and does NOT assist with insurance billing issues.
- Ginkgo Gold Acupuncture, upon request, can provide a superbill for you to submit to your insurance company for reimbursement. The superbill request needs to be submitted within **6** months of your visits.

By signing, I confirm that I have read, understand, and accept the billing policy, and I authorize Ginkgo Gold Acupuncture to charge my credit card for agreed-upon purchases.

Signature _____ Date _____

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Cancellation Policy

1) Cancellation and rescheduling must be made to (509) 903-6618 (call/text) or GinkgoGoldAcupuncture@gmail.com, or through Patients' "My Account" on JaneApp at least 24 hours before your appointment. Please Do Not reply to the SMS reminder message.

2) A fee of a **50% full-service charge** applies for a no-show or a late cancellation (including late rescheduling).

3) Patients who have made two late cancellations (including late reschedulings) must pre-pay their appointments.

4) Patients who have missed two appointments without a prior notice will have all future appointments canceled; they will be considered new patients and only pre-paid appointments are available.

By signing, I confirm that I have read and understand the cancellation policy listed above, and I authorize Ginkgo Gold Acupuncture to charge my credit card for the fees listed above if they occur.

Signature _____ Date _____