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?

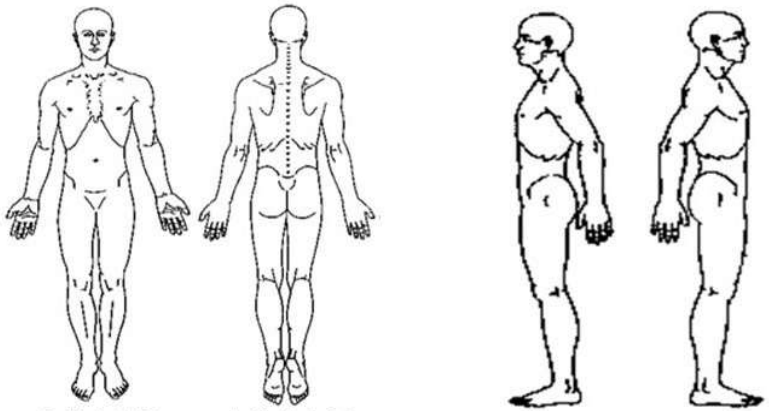
_____

4. Does the pain radiate? Where?

_____

5. How long have you had this pain?

_____



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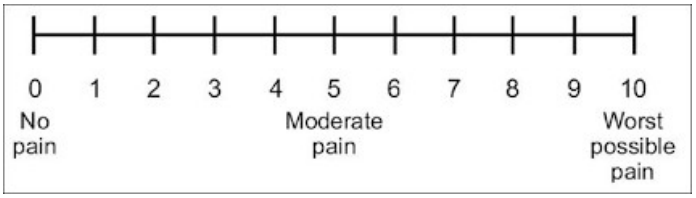

6. What helps to reduce the pain _____

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

Address: 1950 Keene Rd, Bldg K, Richland WA, 99352

Call/text: (509) 903-6618; Email: GinkgoGoldAcupuncture@gmail.com

Treatments and Rates

(Effective 2026-01-01)

At Ginkgo Gold Acupuncture, we strive to provide the best holistic solution for your health and well-being. We offer various levels of treatments for different complexities of patients' healthcare and wellness needs. You and your doctors work together to choose the best option for you.

Ginkgo Gold Acupuncture accepts cash, debit/credit cards including flexible spending account (FSA), and does NOT accept insurance or checks; all payments are due at the time of the service.

Ginkgo Gold Acupuncture, upon request, can provide a superbill for you to submit to your insurance company for reimbursement.

Type of Treatments		Scope	Session Duration**	Rate***	
				Huang	Faix
Initial Visit*	A	Consult, exam, treatment (one side), and follow-up treatment plan	90 min	$155	$145
Follow-up Visit	Basic (B)	Focus on one health condition/wellness need	60 min	$125	$115
	Extended (C)	Treatments for two or more health conditions and wellness needs; more needles and care time for holistic care	90 min	$145	-
	Intensive (D)	**Front** and **back** treatments for intensive, holistic care (suggested for patients with multiple conditions)	120 min	$215	-

* Including patients not seen in the past 12 months.

** Estimated, depending on patients' conditions.

*** $5 credit if paying cash.

Dr. Huang (Xiaoyuan), Clinic Founder, treats a variety of complex conditions, including complex pain.

Faix (Jonathan), L. Ac., focuses on pain management.

Patients are welcome to choose either physician and switch if they determine the other one is a better fit for their care.

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Acupuncture Informed Consent to Treat

I, _____ (print name of the patient), hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me by a licensed acupuncturist at Ginkgo Gold Acupuncture in Richland WA.

I understand that methods of treatment may include, but are not limited to: acupuncture, acupressure, electrical stimulation, cupping, lancets, moxibustion, TDP (specific electromagnetic spectrum) lamp, TuiNa, GuaSha (dermal friction), Chinese herbal medicine, dietary advice and health education, breathing/relaxation/East Asian exercise techniques.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects including bruising, numbness, tingling, infection, pain following treatment, broken needle, and dizziness or fainting.

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 may be 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 gastrointestinal issues and allergic reactions. I understand that the herbs need to be prepared and the tea consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately inform the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs and/or teas. I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgement during the course of treatment which the clinical staff thinks at the time, based on upon facts then known is in my best interest. I understand that results are not guaranteed.

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.

I understand it is my responsibility to inform the clinical staff if I am pregnant or intending to become pregnant, have severe bleeding disorder, or have a pacemaker prior to any treatment.

Patient Signature _____ Date _____

(If a patient representative signs for the patient)

Name	Signature	Relationship to Patient	Date
_____	_____	_____	_____

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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 _____