



## 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? No \_\_\_\_, Yes \_\_\_\_, 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

- |                                      |                                           |                                              |                                             |
|--------------------------------------|-------------------------------------------|----------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS/HIV    | <input type="checkbox"/> Eating disorders | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice           |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Epilepsy         | <input type="checkbox"/> Hi Fevers           | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Cancer      | <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Hypothyroid         | <input type="checkbox"/> Measles            |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Hyperlipidemia      | <input type="checkbox"/> Meningitis         |
| <input type="checkbox"/> Diabetes    |                                           |                                              | <input type="checkbox"/> Multiple Sclerosis |

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

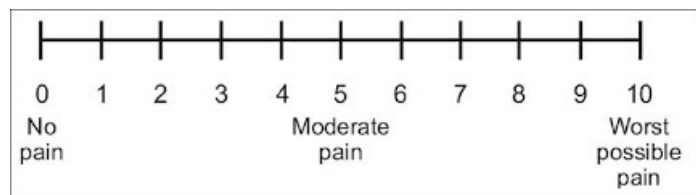
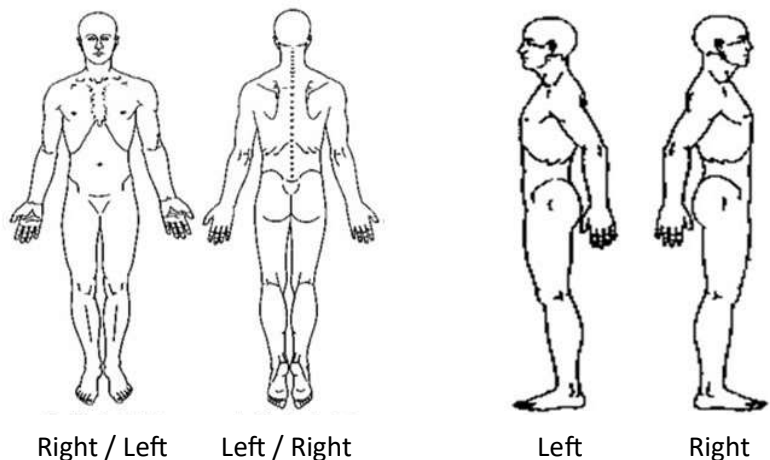
\_\_\_\_\_

4. Does the pain radiate? Where?

\_\_\_\_\_

5. How long have you had this pain?

\_\_\_\_\_



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:** \_\_\_\_\_



Dr. Huang, Xiaoyuan

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

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

## Treatments and Rates

(Effective 2025-08-08)

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 doctor 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***   |              |
|--------------------|---------------|------------------------------------------------------------------------------------------------------------------------|--------------------|-----------|--------------|
|                    |               |                                                                                                                        |                    | Dr. Huang | Dr. Faix**** |
| Initial Visit*     | A             | Consult, exam, treatment (one side), and follow-up treatment plan                                                      | 90 min             | \$145     | \$125        |
| Follow-up Visit    | Basic (B)     | Focus on one health condition/wellness need                                                                            | 60 min             | \$115     | \$95         |
|                    | Extended (C)  | Treatments for two or more health conditions and wellness needs; more needles and care time for holistic care          | 90 min             | \$140     | -            |
|                    | Intensive (D) | <b>Front</b> and <b>back</b> treatments for intensive, holistic care (suggested for patients with multiple conditions) | 120 min            | \$195     | -            |

\* Including patients not seen in the past 12 months.

\*\* Estimation

\*\*\* \$5 credit if paying cash.

\*\*\*\* Focus on pain management

*Ginkgo Gold Acupuncture reserves the right to explain, modify, suspend or discontinue any and all of the practices, policies, and programs at any time without notice.*



## 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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## 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 \_\_\_\_\_

# Cancellation Policy

- 1) Cancellation and rescheduling must be made to **(509) 903-6618** (call/text) or **GinkgoGoldAcupuncture@gmail.com** at least **24 hours** before your appointment. **Do Not** reply system reminder messages.
- 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 \_\_\_\_\_