Chinese Acupuncture & Herb Center

Expertise You Can Count On

Name_____ F___M___ Birth Date___/_____/_____

Street Address_____City_____State____ZIP_____

Home Phone_____-_____-_____ Mobile Phone _____-_____-_____ Work Phone _____-_____-_____

Email Address_____ Preferred contact method_____

Primary Insurance Company_____

Secondary Insurance Company_____

Occupation_____ Employer Name_____

Emergency Contact_____ Phone _____-_____-_____ Relationship_____

Primary Physician_____ Clinic Name_____

How did you hear about us?

Referral: Physician ____ Name _____ Clinic Name _____

Recommendation: Other Patient_____ Friend_____ Name_____

Online: Our Website____ Facebook____ Web Search____ Insurance website____

Other (please explain) _____

Health History

Why you are seeking Acupuncture today: _____

Have you received a diagnosis for this condition? ___Yes____No Diagnosis_____

Are you under the care of another health care provider/physician for this condition? _____Yes _____No

Please describe your general health: _____

Please circle any of the following which are part of your medical history

Aids/HIV	Cancer	Heart Disease	Thyroid Disorder
Allergies	Chemical Dependency	Heart Attack	Trauma
Anxiety	Depression	High Blood Pressure	Ulcers
Arteriosclerosis	Diabetes	Hepatitis	Venereal Disease
Asthma	Emphysema	Seizure	Other Conditions
Arthritis	Fibromyalgia	Stroke	_____

Please list all previous surgeries (types and dates): _____

_____

Please list all of your current medications below (Prescription, over the counter, and supplements/herbs)

_____

List all drug and food allergies_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Print your name _____

I acknowledge that Chinese Acupuncture & Herb Center has provided me with a copy of the Chinese Acupuncture & Herb Center Notice of Privacy Practices document. I understand this form means only that I have received the Notice, and in no way affects the care I receive at Chinese Acupuncture & Herb Center. In accordance with the United States Federal Government HIPPA rules, please sign this document and return it to the front desk.

Signature_____Date____/____/_____

Relationship to patient (if signature is not that of patient) _____

CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. You may revoke any of your authorizations at any time; however your revocation must be in writing. You have a right to refuse consent for disclosure of your personal health information. Without your consent, however, we will not be able to submit clams to insurance carriers or other third party payers and may not accept you as a patient.

***By signing below, I give my consent to Chinese Acupuncture & Herb Center to disclose my personal health information.**

Printed Name_____

Signature _____Date____/____/_____

Authorized Provider Representative _____Date____/____/_____

Financial Policies

- If your insurance policy offers acupuncture coverage, we will gladly submit the claims for you. We can advise you on your insurance benefits, but we **cannot guarantee** payment from your insurance company.
    - You are responsible for your deductible, your co-pay and co-insurance.
    - If your insurance denies payment of your claim, you will be held responsible for the charges.
- Without insurance coverage, you will be responsible for paying the charges at the time of treatment. The charge for the initial visit includes both the initial consultation charge and the acupuncture charge listed below.
    - Initial Consultation $45
    - Initial Consultation with Dr. Hu $75 or Dr. Chin
    - Acupuncture Treatment $75.00

By signing below you are agreeing to the above policies, and accepting financial responsibility for your treatments.

Signature_____Date____/____/_____

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture on myself (or on the patient named below, for whom I am legally responsible) by the acupuncturist employed by the Chinese Acupuncture and Herb Center. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that methods of treatment may include, but are not limited to: acupuncture, cupping, electrical stimulation, Tui Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

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, as well as dizziness and fainting. Extremely rare risks of acupuncture include nerve damage, miscarriage, and organ puncture (including lung puncture – pneumothorax). Infection is another possible risk, though the clinic uses sterile, single-use, disposable needles and maintains a clean and safe environment.

Burns and/or scarring are a potential risk of moxabustion or cupping, or when the treatment involves the use of heat lamps. Practitioners are highly trained to avoid and minimize these risks.

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 the herbs may need to be prepared and the teas consumed according to the instructions provided orally and/or in writing. The herbs may have an unpleasant smell or taste. I will notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs. I understand that some herbs may be inappropriate during pregnancy. Some possible herbal side effects are: nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify my practitioner if any of these side effects occur, or if I am pregnant 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 judgement during the course of treatment, based on known facts, and make decisions in my best interest. I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient records and lab reports, but all of 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 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 conditions for which I seek treatment.

Printed Name_____

Signature _____Date____/____/_____