Welcome to Medical Acupuncture

AcuHeal, LLC D.B.A. Medical Acupuncture

Your team here at Medical Acupuncture will be the only people to review these forms. Our ability to draw effective conclusions about the present state of your health and how to improve it depends greatly on your ability to respond thoroughly and accurately. Your careful consideration of each of the following questions will enhance our efficiency in treating you and will provide a more effective use of your scheduled sessions. Other questions will be posed by the physicians and staff in a continuous effort to help improve what's bothering you. Your confidentiality will be strictly maintained. Thank you for your time, and we look forward to working with you to help you achieve your health goals.

General Patient Information

Name Last _____ First _____ **Today's Date** _____

Date of Birth: _____ **Age**: _____ **Gender**: Male / Female **Marital Status**: Married / Single

Height: _____ **Weight:** _____ lbs. **Dominant hand:** Left / Right

Are you able to communicate your medical condition in English without an interpreter? Yes / No

Primary Phone # _____ May we text appointment reminders to this number? Yes / No

Secondary Phone # _____ May we text appointment reminders to this number? Yes / No

Email _____ **last 4 of SSN** XXX - XX - _____.

Street Address _____

City _____ **State** _____ **Zip** _____

May we mail greeting cards to this address? Yes / No

Place of employment _____ **Occupation** _____

If retired, what did you do before retirement?

Does your work involve ☐ labor intensive ☐ work from home ☐ sitting in front of computer (____ hours a day, ___ days a week)

Mediciations (if any) _____

_____

Supplements (if any vitamins, herbs, etc.) _____

_____

Are you on a special diet? Yes / No . If yes, Please specify _____

Are you allergic to any plant, food, oil, medication, or anything else? Yes / No.

If yes, Please specify _____ The effect on you _____

Emergency Contact Information

Name Last _____ First _____

Relationship to You _____ **Emergency Phone #** _____

How did you hear about us?

☐ VA ☐ Referred by_____ ☐ Drive by ☐ Internet ☐ Facebook ☐ Other _____

Current Condition Please skip questions which you feel do not apply to your condition.

Chief Complaint (the reason for your visit today) Please list **ONE*** _____

*You have the opportunity to list more on the next page.

- **It started** ▢ gradually ▢ suddenly

  since: Month _____ Year _____, worse especially in the last _____ days / weeks / months / years

  Have you ever had this or similar condition even before this time period? ▢ Yes ▢ Never, this is new

- **What caused the condition?** _____ ▢ I'm not sure / I don't know

- **It is** ▢ quickly deteriorating ▢ progressively worsening ▢ staying about the same as first happened

  ▢ slowly getting better but abnormally slow ▢ plateaued after some improvement at beginning

- **My pain level in 0-10 (10 being the worst)** today _____/10, on a bad day _____/10, with medication _____/10
- **My pain tolerance level** ▢ very low ▢ low ▢ moderate ▢ high ▢ very high
- **My pain is** ▢ constant ▢ frequent (daily / several times a week) ▢ intermittent ▢ motion triggered ▢ occasional
- **My pain is (check all that apply)** ▢ sharp ▢ dull ▢ deep ▢ aching ▢burning ▢ stabbing ▢ nagging ▢ cramping

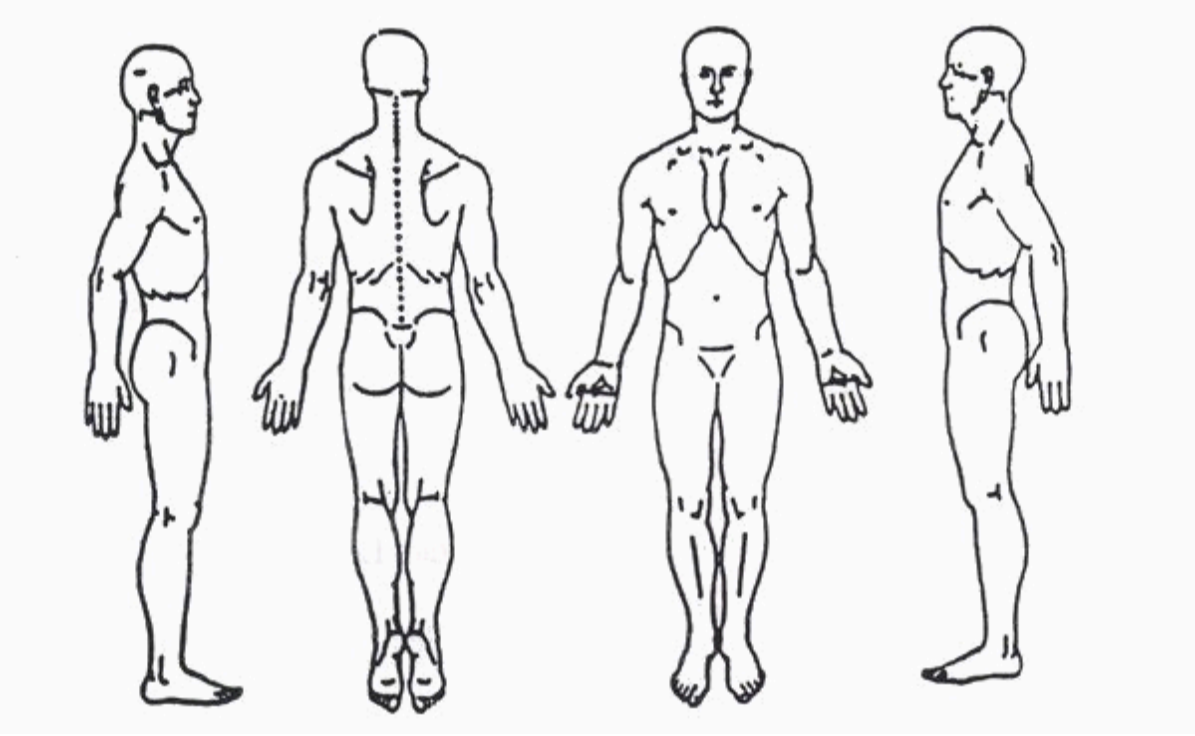
  ▢ numbness ▢ tingling ▢ pins and needles ▢ throbbing ▢ moving ▢ fixed ▢ weakness ▢ excruciating

  Please describe any additional sensation you experience _____

Do you need assistance with walking, getting undressed/dressed, getting on/off the treatment table? Yes / No

Please mark areas affected in the diagram below.

ROM:



How does this condition affect you? (check all that apply)

▢ work ▢ daily routine ▢ sleep ▢ mood/emotion ▢ quality of life ▢ family/marriage/social life ▢ sports activities

▢ driving ▢ range of motion ▢ concentration ▢ memory ▢ weight loss/gain ▢ self confidence/esteem

Please explain in details _____

_____

When is your condition worse? ▢ all the time ▢ first wake up in the morning ▢ with more activities ▢ during sleep

▢ when tired ▢ prolonged sitting/standing/walking ▢when first initiating motion after staying still ▢ as the day goes on

▢ after activities ▢ not sure ▢ unpredictable ▢ weather specific: cold / rain / hot / dry ▢ stress / emotional upset

What makes your condition worse? _____

What helps your condition?_____

Do you have or had (check all that apply)

▢ degenerative disease ▢ progressive condition ▢ traumatic injury(ies) ▢ food sensitivity/allergy ▢ pacemaker

▢ torn muscles / tendons / ligaments ▢ artificial body part(s) _____ ▢ organ removed _____

▢ spine fusion ▢ metal hardware _____

Are you using (check all that apply) ▢ cane ▢ walker ▢ scooter ▢ wheelchair ▢ other assistive device

Have you tried ▢ physical therapy ▢ aqua therapy ▢ chiropractic care ▢ acupuncture ▢ massage ▢ shots

Please indicate your goal

▢ symptom relief only ▢ slow down/prevent further degeneration ▢ elimination of root cause

▢ whatever help I can get ▢ other:_____

Success criteria: Please describe the improvement you expect.

If you would, please include specific goals you wish to reach and/or activities you wish to be able to do or resume.

_____

_____

Other complaints

- _____

  since: Month _____ Year _____, worse especially in the last _____ days / weeks / months / years
- _____

  since: Month _____ Year _____, worse especially in the last _____ days / weeks / months / years
- _____

  since: Month _____ Year _____, worse especially in the last _____ days / weeks / months / years

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OFFICE USE ONLY

Medication for CC ▢ _____ ____ mg QD / BID / TID / PRN

_____ ____ mg QD / BID / TID / PRN

Patient Medical History

Please list ALL healthcare providers (family physicians, surgeons, specialists, chiropractors, nutritionist, physical therapist, occupational therapist, speech therapist, counselor, etc.) who are currently treating you:

Name	Disorder you are being treated

We find that when all of your healthcare providers are up to date with your treatment progress, it makes it easier for all of us to better help you improve your health. **Is it okay if we contact the above healthcare providers to update on the treatments you are receiving here? Yes / No**

Have you ever been hospitalized? Yes / No If yes, please explain below:

(1) Month _____ Year _____ Reason _____

(2) Month _____ Year _____ Reason _____

(3) Month _____ Year _____ Reason _____

Please use the back of this page for any additional hospitalization history.

Have you ever had any surgeries or operations? Yes / No If yes, please explain below:

(1) Month _____ Year _____ Reason _____

(2) Month _____ Year _____ Reason _____

(3) Month _____ Year _____ Reason _____

Please use the back of this page for any additional surgery or operation history.

Have you ever had any injuries (including a fall when you were just a little kid, motor vehicle accident, sports injuries, broken bones, serious falls, knocked out unconscious)? Yes / No If yes, please list below:

(1) Month _____ Year _____ Reason _____

(2) Month _____ Year _____ Reason _____

(3) Month _____ Year _____ Reason _____

Please use the back of this page for any additional injury history.

Are you currently on blood thinner? Yes / No

Do you have a pacemaker or defibrillator? Yes / No

Please check any you ever had any of the following:

- ▢ AIDS/HIV
- ▢ alcoholism/drug addiction
- ▢ allergy
- ▢ allergy shots
- ▢ anemia
- ▢ anorexia
- ▢ arthritis (OA/RA)
- ▢ asthma
- ▢ autoimmune disorder
- ▢ bladder disease (UTI, IC)
- ▢ bleeding disorders
- ▢ blood pressure (too high/too low)
- ▢ bulimia
- ▢ cancer
- ▢ chicken pox
- ▢ concussion
- ▢ diabetes (DM1/DM2)
- ▢ epilepsy/seizures
- ▢ gallbladder disease
- ▢ goiter
- ▢ gonorrhea
- ▢ gout
- ▢ fibromyalgia
- ▢ heart attack
- ▢ heart disease
- ▢ hepatitis
- ▢ HIV
- ▢ infertility
- ▢ kidney disease
- ▢ liver disease
- ▢ low blood sugar
- ▢ lung disease
- ▢ measles
- ▢ miscarriage
- ▢ mononucleosis
- ▢ MS
- ▢ mumps
- ▢ neuropathy
- ▢ paralysis
- ▢ Parkinson's Disease
- ▢ polio
- ▢ prostate problems
- ▢ prosthesis
- ▢ psychiatric care
- ▢ Scarlet fever
- ▢ severe electrical shock
- ▢ skin disorders
- ▢ stomach ulcers
- ▢ stroke/mini stroke (TIA)
- ▢ suicide attempt
- ▢ thyroid dysfunction
- ▢ tuberculosis (TB)
- ▢ typhoid fever
- ▢ whooping cough

Family Medical History

Please check the following that have occured in your *blood* relatives: ▢ adopted (please skip this section)

- ▢ AIDS
- ▢ alcoholism/drug addiction
- ▢ arthritis(OA/RA)
- ▢ allergies
- ▢ asthma
- ▢ autoimmune disease
- ▢ cancer
- ▢ concussion
- ▢ diabetes (DM1/DM2)
- ▢ epilepsy/seizure
- ▢ fibromyalgia
- ▢ heart attack
- ▢ heart disease
- ▢ hepatitis
- ▢ high blood pressure
- ▢ HIV
- ▢ IBS
- ▢ kidney disease
- ▢ lupus
- ▢ MS
- ▢ paralysis
- ▢ STDs
- ▢ stroke
- ▢ TIA (mini stroke)

No Show, Late, and Cancellation Policy

Description

"No-Show" shall mean any patient who fails to arrive for a scheduled appointment. "Same Day Cancellation" shall mean any patient who cancels an appointment less than **48 hours** before their scheduled appointment. "Late Arrival" shall mean any patient who arrives at the clinic 15 minutes after the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. Medical Acupuncture's goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required to call or leave a message at least **48 hours** before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Fees

"No-Show" will be subject to a **100% of service fee (no refund)**.
"Same-Day Cancellation" will be subject to a **$65.00 Late Cancellation Fee**. ($25.00 for therapy room access only appointment.)
"Late Arrival" which is rescheduled for another time or day will be subject to **$65.00 Late Arrival fee**.
It is your responsibility to pay these fees in full prior to scheduling your next appointment. INITIAL X_____

Procedure

I. A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

II. Established patients:

a. Appointment must be canceled at least **48 hours** prior to the scheduled appointment time.
b. In order to accommodate other patients whose appointments follow, in the event a patient arrives late as defined by "late arrival" to their appointment, their visit will not be extended and end at the allotted time. Out of respect and consideration for your physician and other patients please plan accordingly and be on time.
c. In the event a patient arrives late as defined by "late arrival" to their appointment, and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available.
d. In the event a patient has incurred two (2) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from Medical Acupuncture. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions, in accordance with Medica Acupuncture guidelines.

III. New patients:

a. Appointment must be canceled at least **48 hours** prior to scheduled appointment time.
b. In the event of a no-show, Medical Acupuncture may require a new referral sent from the referring physician and/or facility.
c. In the event a patient arrives late as defined by "late arrival" to their appointment, Medical Acupuncture reserves the right to request a new referral sent from the referring physician and/or facility.
d. In the event of two (2) documented "same-day cancellations," the patient may be subject to dismissal from Medical Acupuncture. The patient's chart is reviewed and dismissals are determined by a physician only, no exceptions, in accordance with Medical Acupuncture guidelines.

I fully understand that by signing below; I am indicating that I have read and understood this policy, that I have been verbally advised, that I have had an adequate and reasonable opportunity to ask questions, that all of this information is mentally and physically clear to me, and that I authorize AcuHeal, LLC. D.B.A. Medical Acupuncture Group to charge applicable fees.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Thank you for your understanding. We appreciate being able to care for you. We understand there can be special unavoidable circumstances which may cause you to cancel with short notice. Please let us know if this happens. In these instances the fee may be waived.

Notice of Privacy Practice

Our Notice of Privacy Practices (“the Notice”) provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section below describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Patient Rights: You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall affect any disclosure we have already made in reliance on your prior Consent. AcuHeal, LLC (“the Practice”) provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in Writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____

Patient Informed Consent

Please read the following and confirm that you agree to and clearly understand them by signing below.

1. The practitioners performing the procedures are Licensed Acupuncture Physician and a Doctor of Oriental Medicine (Florida). In the State of Florida, such a practitioner is a primary Health Care Provider (Florida Statutes 457.102) with limited Prescriptive Rights. However, this practitioner is NOT a Medical Doctor.
2. The practitioners performing the procedures have graduated with Masters Degrees from accredited school and are also nationally board certified by the NCCAOM (The National Certification Commission for Acupuncture and Oriental Medicine).
3. The Practitioners are licensed to use adjunctive therapies (such as laser acupuncture, homeopathy, thermal therapy, therapeutic exercises, lifestyle counseling, and other) and herbal or nutritional therapies into his/her practice.(FS Law 64B1-4.008 and 64B1-4.004).
4. I hereby voluntarily request and consent to the performance of the acupuncture treatment and other procedures within the scope of the practice of acupuncture on myself (or the patient named below for whom I am legally responsible) by licensed acupuncture physicians and those working at the clinic whether signatories to this form or not.
5. I understand that methods of treatment may include, but are not limited to, acupuncture (with or without electrical stimulations), acupressure, ear acupuncture, scraping, Nerve Reboot Therapy, injections, homeopathic medicine, compression therapy, Chinese herbal medicine, supplements, and nutritional and/or lifestyle counseling.
6. I request and approve Oriental Medical procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, range o motion, muscle and orthopedic testing; modes of manual or physical therapy such as scraping, manipulation of joints and/or viscera, heat and/or cold therapy, and elector and/or magnetic stimulation; the prescription of herbal and homeopathic medicines as well as dietary supplement; dietary recommendations; exercise advice and healthy lifestyle counseling.
7. I have been informed that acupuncture is a generally safe method of treatment and acknowledge that it may have some side effects including bruising, numbness or tingling near the needling sites that may last a few days, dizziness, and/or fainting. Unusual but possible risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncture including pneumothorax. Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment to minimize such risks.
8. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.
9. 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 and FDA approved although some may be toxic in large doses.
10. 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.
11 I understand that the Chinese herbal formulas need to be consumed according to the instructions provided orally and in writing. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.
12. I acknowledge the cost of the “Customized Herbal Prescriptions;” are NOT included in the standard service fee and/or any and all variations of the Health Care Plan(s) as these prescriptions are based on each individual need. Payment for any and all personalized prescriptions IS ADDITIONAL and such payment will be due the day the formula is ordered per request of a patient. Personalized prescriptions CANNOT be returned or refunded. INITIAL X_____
13. I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on the practitioner to exercise such judgment during the course of my treatment as the practitioner feels at the time, based on the facts known, to be in my best interest.
14. Financial Information: All fees are due in full at the time of finalizing appointment, unless prior arrangements have been made with AcuHeal, LLC., d.b.a. Medical Acupuncture (“the Practice”). I hereby acknowledge and accept full responsibility for any and all costs incurred. Payment is made directly to AcuHeal, LLC or its affiliates for the amount due, as stated above. Payment can be made by cash, any major credit/debit card, or FSA/HSA card.
15. The Practice is a cash based practice and is out of network with all health insurance companies. This means the Practice is not under a contractual agreement with any health insurance companies; therefore, does not follow any health insurance companies' guidelines or policies.
16. The Practice will provide a superbill upon my request for me to submit to my health insurance company. I understand that a superbill is not a guarantee of reimbursement from my health insurance company. In addition, the Practice will not submit a claim on behalf of me. It is my responsibility to file a claim.
17. I understand that any and all communications and negotiations with my insurance company are my responsibility.
18. I understand that I am responsible for the balance my health insurance company does not pay.
19. Authorization to Use and Disclose Health Information: I authorize the release of any of my medical information to my referring physician, if any, and/or to my health insurance company for the purpose of assessing claims. This information includes records of examination, diagnosis, treatment and billing information during the duration of care. I also authorize AcuHeal LLC, D.B.A. Medical Acupuncture to obtain my medical records from other physicians or medical facilities.
20. This agreement assumes full cooperation on part of the patient. This cooperation includes and is not limited to patient’s agreement to remain active in the recommended program. Hence, compliance to recommended schedules is equally important and the patient agrees to keep appointments to the best of their ability.
21. Refunds will be provided within 7 business days of the request from the patient. Restrictions apply. Please read “No Show, Late, and Cancellation Policy” on page 5 of this patient package.
22. I understand that this agreement is not a guarantee of success or effectiveness of a specific treatment or series of treatments. Any balance due for services is regardless of results & treatment outcome. Refunds will not be provided on the basis of treatment outcome.
23. I understand that all my questions regarding any procedures will be answered, and that I am free to withdraw my consent and to discontinue treatment at any time.

I fully understand that by signing below, I am indicating that I have read and understood the information in this consent form; that I have been verbally advised and that I have had an adequate and reasonable opportunity to ask questions, that I have received all of the information I desire about the practitioner and any and all procedures, and that all of this information is mentally and physically clear to me, and that I authorize AcuHeal, LLC, D.B.A. Medical Acupuncture to perform the procedures.

Patient Name (Please Print): _____

Patient Signature: _____ Date: _____