

# Acupuncture Alexandria, LLC

## PATIENT INFORMATION FORM

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Suffix \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

E-mail: \_\_\_\_\_

Appointment reminders by:  e-mail  text  both

I put out a monthly newsletter. Check here  if you would not like to be included.

Sex: (Circle) M F Other Marital Status (circle) Single Married Other

Employment: (Circle) Employed Unemployed Disabled Retired Student

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_

Responsible Party (if dependent): \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

### **In Case of Emergency, Contact:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone/Contact info: \_\_\_\_\_

### **How Did You Hear About Our Clinic?**

(Please circle) Other health practitioner Internet Family/Friends Insurance company

Walk-in Event \_\_\_\_\_ Other \_\_\_\_\_

## Acupuncture New Patient Health History Form

**Reason for today's visit:** \_\_\_\_\_

Yes, I have been treated by Acupuncture before. Date of last treatment: \_\_\_\_\_

Yes, I am currently under a Physician's care for: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Yes, I am currently taking prescription drugs. Please list below:

Drug Name & Dosage	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Yes, I am currently taking supplements and/or vitamins. Please list below:

Supplement/Vitamin Name & Amount	For What Purpose/Condition
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Yes, I have an infectious disease. Please describe: \_\_\_\_\_

Yes, I have allergies. Please indicate:

Foods  Medications  Bites/Stings  Seasonal  Animals  Other

Describe \_\_\_\_\_

**Family Medical History** (Please check if any of the following applies to any family members)

AIDS  Alcoholism  Allergies  High Blood Pressure  
 Asthma  Diabetes, Type I/II  Heart Disease  Cancer  
 Seizures  Stroke  Mental Illness  Other: \_\_\_\_\_

**Personal Health History** (Please check if any of the following apply)

AIDS  Diabetes  Hepatitis  
 Alcoholism  Emphysema  High Blood Pressure  
 Asthma  Epilepsy  Multiple Sclerosis  
 Allergies  Endocrine Disorder  Thyroid Disease  
 Arteriosclerosis  Gout  Childhood Fevers  
 Birth Trauma (yours)  Heart Disease  Childhood Illnesses

Major Surgeries (please list all with approx. dates): \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Significant Trauma (auto accidents, falls, etc. Please list with approx. date of injury):

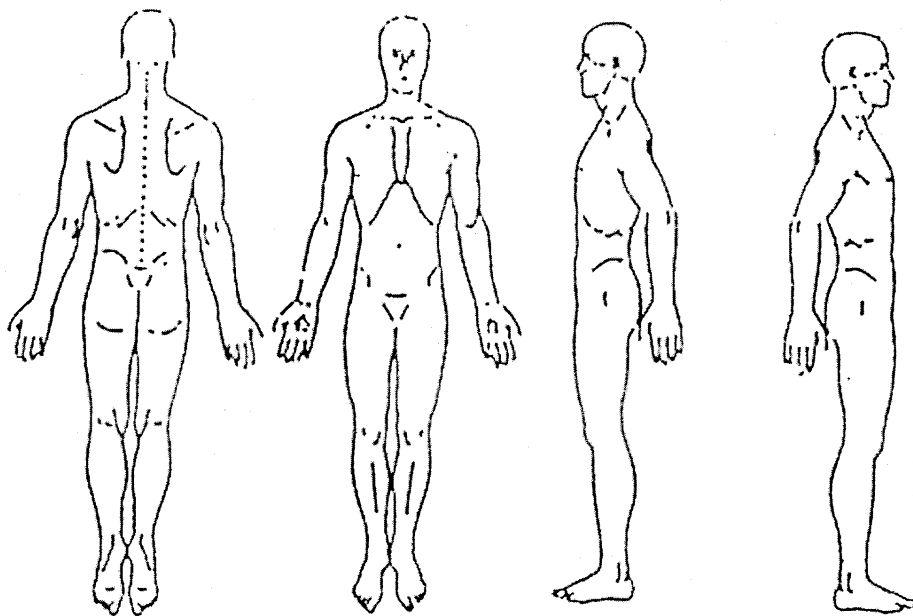
\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Symptoms** (Please check if any of the following apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Urination Difficulties  | <input type="checkbox"/> Constipation/Diarrhea |
| <input type="checkbox"/> Vision Problems        | <input type="checkbox"/> Infertility             | <input type="checkbox"/> Skin Disorders        |
| <input type="checkbox"/> Jaw/Teeth Pain         | <input type="checkbox"/> Impotence               | <input type="checkbox"/> PMS                   |
| <input type="checkbox"/> Ear Pain               | <input type="checkbox"/> Muscular Pain           | <input type="checkbox"/> Menstrual Disorders   |
| <input type="checkbox"/> Sinus Pain/Problems    | <input type="checkbox"/> Joint Dysfunction/Pain  | <input type="checkbox"/> Menopausal Problems   |
| <input type="checkbox"/> Throat Pain/Problems   | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Anxiety               |
| <input type="checkbox"/> Breathing Difficulties | <input type="checkbox"/> Depression              | <input type="checkbox"/> Chest Pain            |
| <input type="checkbox"/> Chills                 | <input type="checkbox"/> Overly Emotional        | <input type="checkbox"/> Excess Thirst         |
| <input type="checkbox"/> Fever                  | <input type="checkbox"/> Fatigue                 | <input type="checkbox"/> Lack of Thirst        |
| <input type="checkbox"/> Indigestion            | <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Spontaneous Sweating  |
| <input type="checkbox"/> Insomnia               | <input type="checkbox"/> Weight Loss             | <input type="checkbox"/> Night Sweating        |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Weight Gain             | <input type="checkbox"/> Lack of Sweating      |

Other: \_\_\_\_\_

**\*\*Please indicate any areas of pain on the diagram below\*\***



**Life Style** (Please check if any of the following apply)

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Live Alone                         | <input type="checkbox"/> Work 9-5                   | <input type="checkbox"/> Exercise Seldom          |
| <input type="checkbox"/> Live with Spouse/Significant Other | <input type="checkbox"/> Work 2 <sup>nd</sup> Shift | <input type="checkbox"/> Exercise Occasionally    |
| <input type="checkbox"/> Live with Roommate(s)              | <input type="checkbox"/> Work 3 <sup>rd</sup> Shift | <input type="checkbox"/> Exercise Often           |
| <input type="checkbox"/> Live with Parents                  | <input type="checkbox"/> Work Inconsistent Hours    | <input type="checkbox"/> Enjoy Hobby              |
| <input type="checkbox"/> Live with Children                 | <input type="checkbox"/> Manage Own Business        | <input type="checkbox"/> Religious                |
| <input type="checkbox"/> Enjoy your work                    | <input type="checkbox"/> Unemployed                 | <input type="checkbox"/> Spiritual Connection     |
| <input type="checkbox"/> Enjoy your Home                    | <input type="checkbox"/> Student Full Time          | <input type="checkbox"/> Have Family Support      |
| <input type="checkbox"/> Enjoy you Social Life              | <input type="checkbox"/> Student Part Time          | <input type="checkbox"/> Have Financial Stability |



# Acupuncture Consent Forms

## Financial Policy

I am committed to providing you with the best service possible. The following is a statement of the financial policy. Please read and sign below prior to your first visit.

Full payment is due at time of service unless prior arrangements have been made. Payment can be made by Visa, MasterCard, Discover, AmEx, check, or cash. A \$20 handling fee will be charged for any returned checks. I am not to be held responsible for any incorrect charges due to any incorrect information given to me at the time of the first visit. It is your responsibility to call your insurance company to find out your acupuncture benefits. I will gladly provide you a super-bill for your treatments and provide any information you need so you can submit the claim yourself.

Charges for the first visit are \$130 and follow-up visits are \$90. Most conditions require an average of 6-12 treatments. Some people will respond well within 4-6 treatments and others may require a longer series – this depends on the severity and the chronic nature of the chief complaint.

**Cancellation/Missed appointments: Appointments missed or canceled with less than 24 hours notice incur a no-show/missed appointment fee of \$50 due before the next treatment.** If you are more than 15 minutes late for your appointment, I may not be able to see you without significant wait to other patients. If this occurs you may be asked to reschedule your appointment and you may be charged for a missed appointment.

## Acupuncture Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist. I understand that acupuncturists practicing in the state of Virginia are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

**Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

**Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

**Acupressure:** I understand that I may also be given acupressure as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

**Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

**Cupping/Gua Sha:** I understand that I may be asked to receive cupping or gua sha therapy administered with the acupuncture. I am aware that bruise-like marks are a common side effect of this therapy. I understand that this treatment is optional and I may refuse it.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

### **HIPAA Consent for Purposes of Treatment, Payment and Health Care Operation**

I consent to the use or disclosure of my identifiable health information by Sarah Shupe L.Ac. and Laura Breeden L.Ac. of Acupuncture Alexandria, LLC for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Sarah Shupe L.Ac. and Laura Breeden L.Ac. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Acupuncture Alexandria, LLC is not required to agree to the restrictions that I may request. However, if Acupuncture Alexandria, LLC agrees to a restriction that I request, the restriction is binding upon Acupuncture Alexandria, LLC.

I have the right to revoke this consent, in writing, at any time except to the extent that Acupuncture Alexandria, LLC has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Acupuncture Alexandria's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Acupuncture Alexandria, LLC. The Notice of Privacy Practices is also provided by Acupuncture Alexandria, LLC at the time of visit or by visiting: <http://www.acupuncturealexandria.com/hippa-privacy-policy/4588591403> and on the organization's web site at <http://www.hhs.gov/ocr/hipaa>. This Notice of Privacy Practices also describes my rights and the duties of my practitioner with respect to my identifiable health information.

Acupuncture Alexandria reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

\_\_\_\_\_ I have read and understood the Financial Policy

\_\_\_\_\_ I have read and understood the Acupuncture Consent to Treatment

\_\_\_\_\_ I have read and understand the HIPAA Consent

\_\_\_\_\_  
Signature (patient or responsible party)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## Recommendation for Examination by a Physician

**Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia §54.1-2956.9, 18 VAC 85-110-10*).**

We Sarah Shupe L.Ac. and Laura Breeden L.Ac. of Acupuncture Alexandria, LLC recommend to you

\_\_\_\_\_ that you be examined by a physician  
(patient)

regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Acupuncturist

\_\_\_\_\_  
Date

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