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 Maritial 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 qMedications __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):

____

____

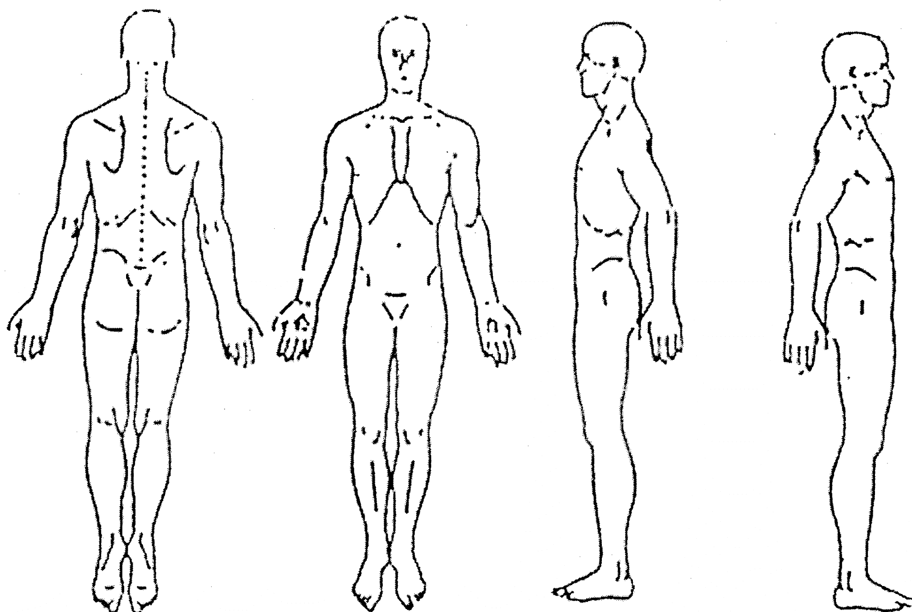
____

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

__Headaches
__Vision Problems
__Jaw/Teeth Pain
__Ear Pain
__Sinus Pain/Problems
__Throat Pain/Problems
__Breathing Difficulties
__Chills
__Fever
__Indigestion
__Insomnia
__Nervousness
__Urination Difficulties
__Infertility
__Impotence
__Muscular Pain
__Joint Dysfunction/Pain
__High/Low Blood Pressure
__Depression
__Overly Emotional
__Fatigue
__Dizziness
__Weight Loss
__Weight Gain
__Constipation/Diarrhea
__Skin Disorders
__PMS
__Menstrual Disorders
__Menopausal Problems
__Anxiety
__Chest Pain
__Excess Thirst
__Lack of Thirst
__Spontaneous Sweating
__Night Sweating
__Lack of Sweating

Other:____

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



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

__Live Alone
__Live with Spouse/Significant Other
__Live with Roommate(s)
__Live with Parents
__Live with Children
__Enjoy your work
__Enjoy your Home
__Enjoy you Social Life
__Work 9-5
__Work 2nd Shift
__Work 3rd Shift
__Work Inconsistent Hours
__Manage Own Business
__Unemployed
__Student Full Time
__Student Part Time
__Exercise Seldom
__Exercise Occasionally
__Exercise Often
__Enjoy Hobby
__Religious
__Spiritual Connection
__Have Family Support
__Have Financial Stability

Diet and Personal Habits (Please check if any of the following apply)

__Currently use Tobacco, # packs per day?_________	__Currently use alcohol, # drinks per week?_________
__Former Tobacco Use, Year Quit?______	__Currently use recreational drugs
__Exercise Regularly	__Vegetarian
__Vegan	__Healthy Diet
__Eat a lot of Fried Foods	__Eat a lot of Dairy
__Eat a lot of Sweets	__Eat a lot of Red Meat
__Normal weight for Height	__Underweight
__Very Overweight	__Overweight

Any additional information about yourself (Please write here)

____

____

____

____

____

____

____

____

____

____

I certify that the information on the health history is correct to the best of my knowledge. I will not hold my acupuncturist or any members of her staff responsible for any errors or omissions I may have made in the completion of this form.

____ ________________________
Signature (patient or responsible party) Date

____
Print Name

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. 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. 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. 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