PATIENT INFORMATION INTAKE FORM

First Name _____ Last Name _____ Middle Initial ____ Sex (M / F) ____

Address _____
(number) (street) (city) (state) (zip code)

Birth Date ____ / ____ / _____ Age _____ Height _____ Weight _____

Phone # (_____) _____ - _____ Cell # (_____) _____ - _____Email_____

Married ( ) Single ( ) Other ( ) _____ Spouse's Name _____

Occupation _____ Employer _____ Work Address _____

Insurance Carrier _____ Member ID #_____ Group#_____ Phone#_____

IN CASE OF AN EMERGENCY, CONTACT_____
Name Relationship Phone #

How did you hear about us? _____ Is this your first time getting acupuncture? Y / N ____

Primary Care Practitioner _____ Phone _____

MEDICAL HISTORY

Please list any allergies/hypersensitivities _____

_____

Please list any medications and/or supplements you are currently taking, including the associated condition(s) _____

_____

_____

Please list any surgeries or major injuries, including dates _____

_____

_____

Are you pregnant? Y / N ___ If yes, how many weeks _____

Do you have a pacemaker or any metal devices in your body? Y / N ____

Last Name: _____

1. What is your **worst** complaint? _____

   When and How did your condition begin? _____

   Rate your pain/discomfort on the scale. (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe) _____

   How often do you experience this complaint? **O**ccasionally **I**ntermittently **F**requently **C**onstantly
   Enter O, I, F, C ____ (0-25% of the day) (26-50% of the day) (51-75% of the day) (76-100% of the day)

   How are your symptoms changing? **Improving** **Not Changing** **Worsening**
   Enter I, N, W _____

2. What is your **second worst** complaint? _____

   When and How did your condition begin? _____

   Rate your pain/discomfort on the scale. (none) = **0 1 2 3 4 5 6 7 8 9 10** = (severe) _____

3. Briefly describe any other complaints: _____

   _____

What aggravates your symptom(s)? _____

What alleviates your symptom(s)? _____

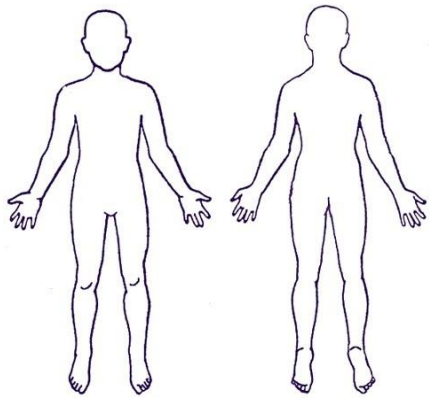
Have you sought other therapies or treatments for the stated condition(s)? Y / N __ List _____

Are you experiencing pain/discomfort in any area of your body? Y / N __ If YES, use the illustration below to mark areas of pain/distress.

Circle any other symptoms you are experiencing.
(Sharp Pain) (Dull Ache) (Shooting Pain)
(Burning Pain) (Throbbing Pain) (Popping) (Weakness)

Please indicate on the diagram to the right where you experience your symptoms. (Use the key below)

Pain X Numbness O Tingling √
Stiffness / Burning +



What would you most like to achieve with acupuncture treatments? _____

_____

_____

Fallbrook CA 92028 **714 330-9244**

Acupuncture Treatment Consent Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substance from the Oriental Materia Medica by **Lori Stephens, L.Ac.**

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 the bodily dysfunction or disease, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse 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.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunctions or disease, 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 movements, abdominal pain/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 practitioner as soon as possible.*

Cupping/Acupressure/Tui-Na: I understand that I may also be given cupping/acupressure/tui-na 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 uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered in the treatment. I am aware that certain adverse 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.

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 more detailed explanation. I give my permission and consent to treatment.

_____ _____

Signature of Patient/Patient Representative Today's Date

_____ _____

Print Name Relationship to Patient

OFFICE POLICIES / PROCEDURES AGREEMENT AND CUSTOMARY FEE SCHEDULE

FINANCIAL ARRANGEMENTS

I understand and agree that health and accident policies are an arrangement between an insurance company carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

INSURANCE BILLING/PAYMENT

Patients are ultimately fully responsible for services provided by our office. For your convenience, our office will make an effort to verify your insurance benefits. However, please note that verification of benefits is not guaranteed. Your insurance company makes the final determination of insurance benefits when they consider the claim. Patients are fully responsible for payment of services not authorized or covered by their insurance company. Patients that are represented by an attorney in PI cases must notify our office the same day if changing or canceling representation.

PAYMENT ARRANGEMENTS

We understand that occasions arise when it may be necessary for you to request to be billed rather than pay at the time of service. This may include setting up a payment plan for those who may require extensive treatments. Payment is due within 30 days of the service rendered. If there are legitimate financial problems, please discuss them with our office manager prior to the 30 days so that we may find a workable solution. If an account is not paid within 30 days and no payment arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account. You will also be charged a monthly interest of 10% based off your principal balance until all fees are paid.

APPOINTMENT SCHEDULING

Canceling or rescheduling appointments requires a 24 hour notice otherwise you will be charged a fee for the missed scheduled service. The charge for a missed appointment without 24 hour notice is $50.

NOTICE OF PRIVACY POLICY

We are required by law to make sure your medical information is protected; give you notice describing our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect. By signing below you are acknowledging that you have received our Notice of Privacy Policy.

NOTICE OF PERMISSON TO TAKE PHOTOS FOR CHART USE

On occasion photos are taken and stored in your chart for the purpose of monitoring progress or placement of needles. These photos are stored in your chart and never posted to any social media

CONSENT TO TREAT MINOR

I, _____ the parent or legal guardian, who has permission to make decisions for _____, a minor child, authorize any necessary treatment at Stephens Acupuncture & Wellness for my minor child and fully agree to the above terms.

_____ _____

Printed Name of Patient | Patient's Signature or that of Legal Representative

_____ _____

Today's Date | If Legal Representative, Indicate Relationship

Acknowledgement of Receipt of Notice of Privacy Practices

This form will be retained in your medical record.

NOTICE TO PATIENT

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

Patient Name:_____ **Date of Birth:**_____

I acknowledge that I have **received and had the opportunity to review** the Notice of Privacy Practices on the date below on behalf of **Stephens Acupuncture & Wellness**

I understand that the Notice describes the uses and disclosures of my protected health information by **Stephens Acupuncture & Wellness** and informs me of my rights with respect to my protected health information.

_____ _____

Patient's Signature or that of Legal Representative *Printed Name of Patient or that of Legal Representative*

_____ _____

Today's Date *If Legal Representative, Indicate Relationship*

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify):_____

_____

_____ _____

Employee Name *Today's Date*