



ACUPUNCTURE & WELLNESS

Would you like to receive a copy of our newsletter containing helpful information about natural medicine and exclusive discounts?

Y

N

Patient Information

Name:

(first)

(middle)

(last)

Social Security Number:

Address:

City:

State:

Zip:

Home Phone Number:

Cell:

Email:

Date of Birth:

Age:

Marital status:

Occupation:

Employer:

Work Address:

City:

State:

Zip:

Phone Number:

Emergency Contact:

Phone Number:

Relationship:

Successful health care and preventative medicine are most effective when the practitioner has a complete understanding of the patient. Please complete this questionnaire as thoroughly as possible. Thank you.

Please list your current health concerns:

List all other present and past diagnoses:

Indicate dates and types of surgeries and injuries

List allergies or sensitivities (past and present):

List any medications (prescribed and over-the-counter), vitamins and supplements you are currently taking:

Does Heritage Acupuncture have your permission to communicate with your primary and/or referring physician(s)? Y N
If so, please list the physician's name(s) and contact number(s)

Family History of (please check):

Heart disease	Food Allergies	Arthritis	Hypothyroidism
Hypertension	Infectious diseases	Asthma	Hyperthyroidism
Hypercholesterolemia	Seizures	Anemia	Adrenal disorders
Hypotension	Cancer	Kidney disease	Diabetes
Stroke	Infertility	Depression	Alcoholism
IBS	Premature menopause	Emotional problems	Autoimmune diseases

Other disorders not listed above:

Have you had any of the above illnesses? Please list

Have you been diagnosed with: Hepatitis B Y N Hepatitis C Y N HIV Y N

Current Height: Weight:

Blood Pressure: What is your most recent blood pressure reading? / When was this reading taken?

Lifestyle

a. Do you typically eat at least three meals per day? Y N If no, how many?

b. Please describe:

A typical breakfast:

A typical lunch:

A typical dinner:

Daily snacks:

Beverages:

Exercise routine:

c. How many hours per night of sleep:

Please indicate use and frequency of the following:

Tobacco

Coffee

Alcohol

Carbonated drinks

Sweets and desserts

Water

Recreational substances

Five Element Questionnaire

Please check if you experience any of the below on a frequent basis (3-5x/week or more):

Wood	Fire	Earth	Metal	Water
Irritability	Palpitations	Body feels heavy	Cough	Urinary pressure or pain
Anger	Dizziness	Fatigue	Nasal discharge	Frequent urination
Depression	Insomnia	Swelling	Sinus pressure	Incontinence
Headaches	Easily startled	Muscle aches	Nose bleeds	Knee pain
Migraines	Anxiety	Craving sweets	Dry mouth	Aching bones
Visual issues	Breathlessness	Excessive hunger	Skin rashes	Feeling cold easily
Red eyes	Vivid dreams	Low appetite	Dry skin	Low sexual energy
Dry eyes	Difficulty concentrating	Frequent worrying	Oily skin	Excess sexual desire
Chest tightness	Lack of joy	Hypoglycemia	Itchy skin	Fear
Lump in throat		Nausea	Shortness of breath	Poor memory
Jaw clenching		Gas	Allergies	Hearing problems
Muscle cramps		Bloating after meals	Frequent colds	Ringing in ears
Stiff joints		Loose stool	Low physical stamina	Night sweats
Acid reflux		Hemorrhoids	Asthma	
Belching				
PMS				

For Women:

Age at onset of menses: _____ First day of last period: _____ Are you pregnant? Y N

Number of: A) Children born B) Miscarriages C) C-sections D) Abortions

Painful periods? Y N Irregular periods? Y N

For Men:

Decrease in urinary flow/pressure: Y N

Premature ejaculation: Y N

Infertility: Y N

Nocturnal emission: Y N

Low libido: Y N

Cash Payment Policy Information

Payment at time of service is required unless you have purchased a series of treatments, available with Facial Rejuvenation services. A \$35 charge applies to all returned checks. Herbal and/or nutritional supplements may be invoiced separately from treatments; payment is requested before delivery of such herbs and/or supplements.

I plan to settle my bill today by paying by cash, MasterCard, Visa, Discover or personal check: Initial

Cancellation Policy

Heritage Acupuncture LLC kindly requests at least 24-hours notice to cancel or reschedule an appointment. Patients who are 20 minutes late or more are considered a no-show. No-shows will be charged 50% of the cost of the scheduled service. Patients who have purchased packages will be charged 50% of the regular cost of the service for the first incident. Additional no-shows for package treatments will result in the reduction of the scheduled treatment from their package. Patients who are scheduled for any treatment or service combination scheduled for more than one hour must provide 48-hours notice to cancel or reschedule. Any service scheduled for a Monday must be cancelled or rescheduled by 5:00 p.m. on the preceding Friday. I understand and agree to the above policies: Initial

Insurance Information

Company: ID Number: Group Number:

Secondary Insurance Company: ID Number: Group Number:

Insurance Payment Policy Information

I understand that all deductibles, copayments and products or services not covered by my insurance plan are my responsibility. Clients with insurance benefits must pay co-payments, if required, at the time of service. Insurance benefits must be verified before undergoing treatment. I understand that it is my responsibility to inform the provider if my insurance plan or provider changes. Should collections be necessary, the patient shall pay Heritage Acupuncture on demand all costs, including reasonable attorney’s fees incurred in collecting payment due for services performed under this agreement. I understand that although insurance benefits may cover certain visits, I am responsible for no show fees should I fail to cancel or reschedule at least 24 hours before an appointment.

Assignment

I permit payment directly to Heritage Acupuncture & Wellness LLC for any benefits due for services rendered and products provided. I understand that I am financially responsible for all charges, whether or not covered by my insurance company. Initial

Medical Records

Authorization is hereby granted for release of any information required to process my insurance claim. A copy of this authorization is as valid as the original. Regardless of any claim pending you will receive periodic statements if your account has an outstanding balance. Heritage cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

Informed Consent and Disclosure

I hereby request and consent to acupuncture, acupuncture-related modalities, herbal recommendations, skin care services and/or other forms of treatment for myself (or my legal charge) provided by Janet Lee, L.Ac., of Heritage Acupuncture LLC, hereby known as the Acupuncturist. I wish to rely on the Acupuncturist to exercise judgment during the course of the procedure and the treatment plan which the Acupuncturist determines in my best interest.

I understand that Acupuncture is one part of Oriental Medicine, which also may include the procedures listed below. I agree to the Acupuncturist's use of these treatments if indicated.

Acupuncture is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the affected area. It also is normal for the patient to have a temporary warm sensation or feeling of pressure at the acupuncture site. Dizziness or temporary fatigue are possible outcomes. I understand that some patients feel a temporary increase in symptoms before they feel relief. Hematoma or bruising also is a possible result of acupuncture treatment. Rare outcomes include skin rash or tingling. Extremely rare possibilities include pneumothorax or other organ puncture.

Acupressure/TuiNa involves rubbing, kneading, pressing and other massage manipulations which may result in muscle soreness at the massage site that can last for several days. This technique and others described here may involve disrobing. I understand that all attempts will be made to assure my privacy.

Indirect moxibustion requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burn exists.

Cupping involves a localized suction produced by creating an oxygen vacuum in a small glass cup. A normal outcome is temporary marks called "sha" which resemble bruises. Slight burning or blistering are also possibilities.

Gua sha involves scraping over a cutaneous area with a smooth instrument. This technique also may result in temporary "sha" marks.

Tapping, plum blossom, bleeding and pricking all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single-use needles are used in these procedures.

Electrical stimulation/TENS uses microcurrent electricity to stimulate acupuncture points. During this technique it is normal to feel a mild tingling sensation.

Treatment using points Ren 1 and Du 1 may be applied in rare cases. This involves using acupuncture points in the perineum area. If this treatment is necessary, the Acupuncturist will notify me and will provide alternative treatments if I am uncomfortable. I understand all attempts will be made to assure my privacy.

Chinese herbalism involves the use of a number of plant and mineral derived medicinals commonly used in Chinese medicine. I understand that the Acupuncturist is trained and licensed for the use of these materials. The use of Chinese herbalism will be determined by the Acupuncturist's expertise. Chinese herbal treatment may occasionally result in digestive upset. I understand that following the Acupuncturist's dosage and usage recommendations for herbal and other supplements is an important part of the treatment outcome.

I understand that Acupuncture and Chinese Medicine are commonly prescribed in a course of treatment, which may include herbalism, dietary recommendations, lab testing and analysis, exercises or other lifestyle changes. I acknowledge that my compliance to these recommendations will affect the treatment plan. I recognize that one treatment is not a course of treatment.

I understand that the Acupuncturist cannot guarantee results and cannot anticipate all possible risks involved in treatment.

I have read or have had read to me the above consent and understand the risks involved. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or suboptimal results. I am aware that it is my responsibility to inform the provider of my current medical or health conditions and to update this history. I understand that the information herein is to aid the provider in giving better service and is completely confidential. The services I receive here are voluntary, and I release Heritage Acupuncture & Wellness LLC and this provider from any liability resulting from this or any services received at Heritage or from any products or tools used during treatments or purchased from Heritage Acupuncture LLC and assume full responsibility thereof.

Authorization for Release of Medical Information: I further understand that the Acupuncturist may need to contact my medical physician when it is determined that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to: the diagnosis of diseases or request for lab and/or radiology results, withdrawal from prescription drugs, severe depression or other conditions. This coordination of care intends to manage my health condition in my best interest and to assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to the Acupuncturist to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that the treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to the Acupuncturist to contact my child's medical doctor if/when necessary.

Patient Name

Date