

**Acupuncture
Associates**

Bellevue: 15100 SE 38th Street Suite 305B Bellevue, WA 98006

Marysville: 1519 9th St. Suite 103 Marysville, WA 98270

New Patient Intake Form

DATE: _____

Name: _____ SS#: _____ Birthday: / /

Marital Status: _____ Age: _____ Male Female Ht _____ Wt _____

Address: _____ City: _____ Zip: _____

Best Contact Phone #: 1.(_____) _____ 2.(_____) _____

Emergency Contact (Name & Phone) _____ Occupation/Employer: _____

Referred by _____

Have you had Acupuncture before? Yes No

Reason for today's visit _____

How Long have you had this condition? _____

Does it bother your: Sleep Work Other (What?) _____

What seemed to make it **better** or **worse**? _____

Is this related to Auto Accident or work injury? If Auto, PIP or PI? _____ DOA: _____

If work related, L&I or company liability? _____

Are you currently under the care of physician? Yes No If yes, for what? _____

Who is your physician?(Name & Phone): _____

Current Medications(any allergies): _____

Other concurrent therapies: _____

Please check ✓ if YES to any of following Medical condition:

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are significant part of your medical history.)

- | | | | | |
|-------------------------------------|--|---|--|--|
| <input type="checkbox"/> AIDs/HIV | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> pregnant |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Trauma | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Surgery (List) | _____ | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | _____ | _____ | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | _____ | _____ | _____ |

YOUR LIFESTYLE

- Alcohol Marijuana
- Tobacco Drugs

- Stress
- Occupational Hazards

- Regular Exercise
- Type: _____
- Type: _____

Frequency: _____
Frequency: _____

GENERAL SYMPTOMS

- Poor appetite Poor sleep
- Heavy appetite Heavy sleep
- Prefer cold drinks Dream disturbed sleep
- Prefer hot drinks Fatigue
- weight gain or loss Lack of strength

- Bodily heaviness
- Cold hands or feet
- Poor circulation
- Shortness of breath
- Fever

- Chills
- Night sweats
- Sweat easily
- Muscle cramps
- Vertigo or dizziness

- Bleed or bruise easily
- Peculiar taste (describe)
- _____
- _____

HEAD/EYES/EARS/NOSE/THROAT

- Glasses Night blindness
- Eyestrain Glaucoma
- Eye pain Cataracts
- Red eyes Teeth problems
- Itchy eyes Grinding teeth
- Spots in eyes TMJ
- Poor vision Facial pain
- Blurry vision Gum problems

- Sores on lips or tongue
- Dry mouth
- Excessive saliva
- Sinus problems
- Excessive phlegm
- Color of phlegm _____

- sore throat
- Lumps in throat
- Enlarged thyroid
- Nose bleeds
- Ringing in ears
- Poor hearing
- Earaches

- Headaches
- Concussions
- Other head or neck problems
- _____
- _____

RESPIRATORY

- Tightness in chest Bronchitis
- Cough
- Productive? _____
- Wet or dry? _____

- Pneumonia
- Color of phlegm _____

- Shortness of breath

- Asthma/wheezing

CARDIOVASCULAR

- High blood pressure Low blood pressure
- Blood clots Fainting

- Chest pain
- Difficult breathing

- Tachycardia
- Irregular heartbeat

- Palpitations

GASTROINTESTINAL

- Nausea Diarrhea
- Vomiting Constipation
- Acid regurgitation Laxative use
- Gas Black stools
- Hiccup Bloody stools
- Bloating Mucous in stools
- Bad breath

- Intestinal pain/cramp
- Itchy anus
- Burning anus
- Rectal pain
- Hemorrhoid
- Anal fissures

Bowel movements:

Frequency _____ Texture/form _____

Color _____ Odor _____

MUSCULOSKELETAL

- Neck/shoulder pain Upper back pain
- Muscle pain Low back pain

- Joint pain
- Rib pain

- Limited range of motion
- Limited use

Other (describe) _____

SKIN/HAIR

- Rashes Eczema
- Hives Psoriasis
- Ulcerations Acne

- Dandruff
- Itching
- Hair loss

- Change in hair
- Fungal infection
- Change in skin texture

Other hair or skin problems _____

NEUROPSYCHOLOGICAL

- Seizures Poor memory
- Numbness Depression
- Tics Anxiety

- Irritability
- Easily stressed
- Abuse survivor

- Considered suicide
- Attempted suicide
- Seeing therapist

Other (specify) _____

GENITO-URINARY

- Pain on urination Blood in urine
- Frequent urination Unable to hold urine
- Urgent urination Incomplete urination

- Venereal disease
- Bedwetting
- Wake to urinate

- Increased libido
- Decreased libido
- Kidney stone

- Impotence
- Premature ejaculation
- Nocturnal emission

GYNECOLOGY

- Age menses began _____
- Duration of flow _____
- Length of cycle _____
- Irregular periods _____
- Painful periods _____
- PMS _____

- Vaginal discharge (color) _____
- Vaginal sores _____
- Vaginal odor _____
- Clots _____

- Breast lumps _____
- #Pregnancies _____
- # births _____
- Premature births _____
- Age at Menopause _____

Date of last PAP _____

Date last period began _____

Acupuncture Associates, P.S.

15100 SE 38th Street Suite 305B
Bellevue, WA 98006
(425)289-0188

Notice of Privacy Practices

Protecting your confidential health information is important to us! This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dear Patient:

This is not meant to alarm you! Quite the opposite! It is our desire to communicate to you that we are taking the new Federal (HIPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your personal health information seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside of our office.

So what has changed?

The most significant variable that has motivated the Federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the internet, phone, faxes, copy machines, and procedures we used to ensure the protection of your health information everywhere it is used. We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient. We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your HEALTH INFORMATION may be used:

To Provide Treatment

We will use your HEALTH INFORMATION within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between Acupuncturist and Naturopathic Physician, Acupuncture and Naturopathic assistant/technician, and business office staff. In addition we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.

For Patient Reminders

Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventive and curative care modern health care can provide. They may include postcards, folding postcards, letters telephone reminders, or electronic reminders such as e-mail (unless you tell us you do not want to receive these reminders).

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law, or with the patient's agreement.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public safety could benefit when the information could lead to control or prevention of an epidemic or the understanding of new side effect of a drug treatment or medical device.

For Law Enforcement

As permitted by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of crime or in order to report a crime.

Family, Friend and Caregivers

We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in your care.

To Coroners, Funeral Directors and Medical Examiners

We may be required be law to provide information to coroners, funeral directors and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Health Care Research

Advancing health care knowledge often involves learning from the careful study of medical histories of prior patients. Formal review and study of health histories as a part of a research study will happen only under the ethical guidance, requirements and approval of an institutional Review Board.

Authorization to Use or Disease Health Information

Other than is stated above or where federal, State or Local law required us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Patient Right

This law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preference our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy your Health Information

You have the right to read, review, and copy your health information, including your complete chart, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process. Please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

Your have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practice directly from our office at any time. Stop by or give us a call and we will mail or –e-mail a copy to you. We are required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of our Privacy Practice. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practice, we will be sure all of our patients receive a copy of the revised Notice. You have the right to express complains to us or to the Secretary of Health and Human Services if you believe your right have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complains in writing.

Patient Acknowledgement

Patient Name (a) _____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not we would appreciate very much your acknowledgment of your receipt of policy by using this Notice.

Patient Signature _____ Date _____

Office Policies and Authorization for Treatment

I, _____, understand that acupuncture is an energetic form of therapy based on the regulation of energy, and is not intended to replace conventional medical treatment. I assume full responsibility for consulting with appropriate physician since I understand that any diagnosis of my condition must be performed by a licensed physician.

I hereby authorize Acupuncture Associates, to perform the following specific procedures:

Acupuncture procedures involving insertion of special needles through the skin into the underlying tissue at specific points on the surface of the body, as well as other techniques as specifically described in the Washington State Law for Licensed Acupuncturists, such as moxibustion, cupping, electroacupuncture and acupressure.

I recognized the potential benefits and risks of the above procedures included reactions as described below:

Potential Benefits: Painless and drugless relief of my presenting symptoms and improved balance of energy, which may lead to prevention, or elimination of the presenting problem.

Potential Risks: Discomfort at the site of insertion of the needle, infections, pain, bruised, weakness, fainting, nausea, and even aggravation of symptoms existing prior to the acupuncture treatment.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given me by Acupuncture Associates, regarding cure or improvement of my condition.

I hereby release Acupuncture Associates, from any and all liability which may occur in connection with the above mentioned procedures, except for failure to perform the procedures with appropriate medical care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

FEE:

I understand that fee for treatment is payable at the time of service unless I am receiving treatment via a medical plan which recognizes Acupuncture Associates, as a Preferred provider. In such an event, payment shall be provided as per the terms of the plan. If it is found I am not eligible for coverage of treatment by my medical plan, I assume full responsibility for paying Acupuncture Associates any money owed for treatment.

MISSED APPOINTMENT:

I will give 24 hours notice if I need to cancel an appointment. I understand without that advance notice, the time reserved for me is my responsibility and will be charged to me as a missed appointment. Missed appointments are charged at the same rates as regular appointment. Insurance companies do not pay for missed appointments so I understand that any appointments missed are my financial responsibility. Exceptional circumstances will be considered regarding this policy.

Signature of Patient

Date

Signature of Person Authorized to consent

Date

Acupuncture Associates

AUTHORIZATION AND FINANCIAL RELEASE AGREEMENT FOR NEW PATIENTS

I _____, being a patient of _____ located at _____, do hereby acknowledge that certain services may not be covered by my insurance under the terms of my Health Plan. I understand that it is my responsibility to know and understand my insurance policy coverage and its benefits. I give authorization to this office to release information regarding my care and treatment to my health plan and its agent for purposes of managing my Health benefit payments to me and/ or my practitioner. I hereby assign to this office any payments my Health Plan makes for services rendered to me and my eligible family members by this office by reason of its contractual relations with my health plan and its agents. I understand that I am responsible to pay for service received at this office and I agree to make financial arrangement with my practitioner to pay for any services not covered by my insurance plan, including, but not limited to, any deductibles, co-payments, co-insurance, or charges for non-covered services.

Dated, _____ (month) _____ (day), 20____.

(Patient signature)

Insurance Plan: _____

Member Identification Number: _____

PROFESSIONAL FEE SCHEDULE

Acupuncture Associates

New Patient Consultation/Examination Consulting based on patient's symptom, Tongue and pulse diagnosis	\$45.00 - \$90.00
Established Patient Consultation/Examination	\$25.00 - \$65.00
Acupuncture Treatment	\$50.00 - \$75.00
Electro Acupuncture Treatment	\$60.00 - \$90.00
Infra-red (TDP) Heat Treatment	\$25.00
Return Check Charge	\$20.00
Missed Appointment Charge	\$35.00

** If I am covered by insurance, I am responsible for any balance not paid within 90 days. Any quote of benefits made to me by Acupuncture Associates is only done as a courtesy and is not a guarantee of payment. I am still responsible for coordination of my insurance.

Thank you for your cooperation

Revised 1/1/2005

Initial & Date _____

Please use the following form to verify if you have Acupuncture Benefits. When you are calling to verify, please make sure you let them know specifically it is for Acupuncture.

Fill out completely and sign. Return to the office when you come in for your first visit.

New Patient Information

NAME: _____ PHONE: _____
DOB: ____ / ____ / ____ Insurance Name: _____
ID #: _____ Group ID #: _____

Insurance Verification

Verified Date: / ____ / ____ Time: _____
Agent Name: _____

Benefits

Effective Date: ____ / ____ / ____ Do I have a waiting period? _____

Do I need a licensed acupuncturist? YES/NO _____

Is this provider?: IN/OUT _____ - of my network?

At what percentage is my coverage? _____ %

Any deductible? _____ \$ How much has been met? \$ _____.

Do I need a referral?: YES/NO _____ Do I need authorization?: YES/NO _____

What is my co pay? \$ _____ What is my out of pocket?: \$ _____

How many visits? _____ /Calendar year or Fiscal year (from _____ - to _____)

How many do I have available? _____ Times _____

Is there anything that is not covered?* *see codes below* _____

Other: _____

*Codes: 99201, 99202, 99203 (consultation/office call for the first office visit), 99211, 99212, 99213 (office call/ consultation), 97810, 97811, 97813, 97814 (Acupuncture Treatment), 97026 (Heat Lamp)

Should you choose to not call and verify your own insurance, Acupuncture Associates will do this for you, however, any quote of benefits given by Acupuncture Associates is only done as a courtesy and is not guarantee of payment.

I am responsible for any balance not paid within 90 days.

Patient's Signature: _____ / Date: _____.