PORT ORANGE ACUPUNCTURE

100 Cessna Blvd, Suite B
Port Orange, FL 32128
(386) 761-8818

Please fill in the following information as completely as possible. In order for us to file for your insurance benefits we must have the information listed below. This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME_____ DATE_____

ADDRESS_____

CITY/STATE/ZIP_____

HOME PHONE_____ CELL PHONE_____

BIRTHDAY_____ AGE_____ MARITAL STATUS_____

PLACE OF EMPLOYMENT_____

WORK PHONE_____ EMAIL_____

Best number to reach you_____ Reminder Calls: Yes_____ No_____

How did you first learn about our office?_____

Major Medical Complaint:_____

Medications:_____

_____

_____

Surgical History:_____

_____

Allergies:_____

INSURANCE: Patients shall pay for office visits at Time of Service. Once we receive the Explanations of Benefits, if anything was paid toward your office visit an adjustment or refund will be issued to your account.

IN NETWORK: UNITED HEALTHCARE_____ CIGNA PPO_____

OUT OF NETWORK: BCBS_____ AETNA_____

Please supply us with a copy of your insurance card.

PATIENT PROFILE

NAME_____ DATE_____

It is very important in Chinese Medicine to know how long a patient has experienced his/her symptoms. It is essential to indicate time on the symptoms.
Please indicate with one check (✓) any conditions that you sometimes experience; use two checks (✓✓) for those which often occur and three checks (✓✓✓) for symptoms that are a major concern.

Water Element
- Hearing Loss
- Dizziness
- Lower Back Pain/Neck Pain
- Sinus Congestion
- Edema
- Darkness under the eyes
- Emotional instability
- Aversion to cold
- Hair thinning or loss
- Pre-mature aging
- Frequent urination
- Kidney stones
- Perspire very easily
- Weakness of the Legs/Knees
- Asthmatic Cough
- Rapid Weight Change
- Asthmatic Cough
- Loose teeth
- Reduced sexual energy
- Thyroid Problems
- Diabetes

Wood Element
- Headache
- Migraines
- Ringing in the ears
- Poor eyesight
- Eye infections
- Dry eyes
- Eczema
- Shingles
- Herpes Simplex
- Warts
- Nervousness
- Convulsions/Spasms
- Irritability
- Constipation
- Hemorrhoids
- Hepatitis
- Irregular Menstruation
- Painful Menstruation
- Ulcer
- Vomiting
- Gallstones
- Indecisiveness
- Fullness below ribs
- Shoulder/neck tension
- Insomnia 11pm-3am

Fire Element
- Dry Scalp
- Skin eruptions, rashes
- Cysts, tumors
- Ear infections
- Sore throat, tonsillitis
- Lymphatic swelling
- Hot palms and soles
- Heart palpitations
- Aversion to heat
- Bitter taste in mouth
- Gum problems
- Nose bleed
- Facial redness
- Itching/burning skin
- Hot hands/ feet
- Thirst
- Dark urine
- Nightsweats

Earth Element
- Indigestion
- Flatulence
- Food Allergy
- Stomach ache/ulcer
- Diarrhea
- Anemia
- Hallitosis
- Mouth sores
- Heartburn
- Strong appetite
- Weak appetite
- Nausea
- Abdominal bloating
- Low body weight

Metal Element
- Bronchitis
- Asthma
- Shallow breathing
- Cough
- Sinus congestion
- Nasal infections

Other
- Fatigue
- Arthralgia
- Sciatica / nerve pain
- Cold hands/ feet
- Tendonitis
- Bursitis

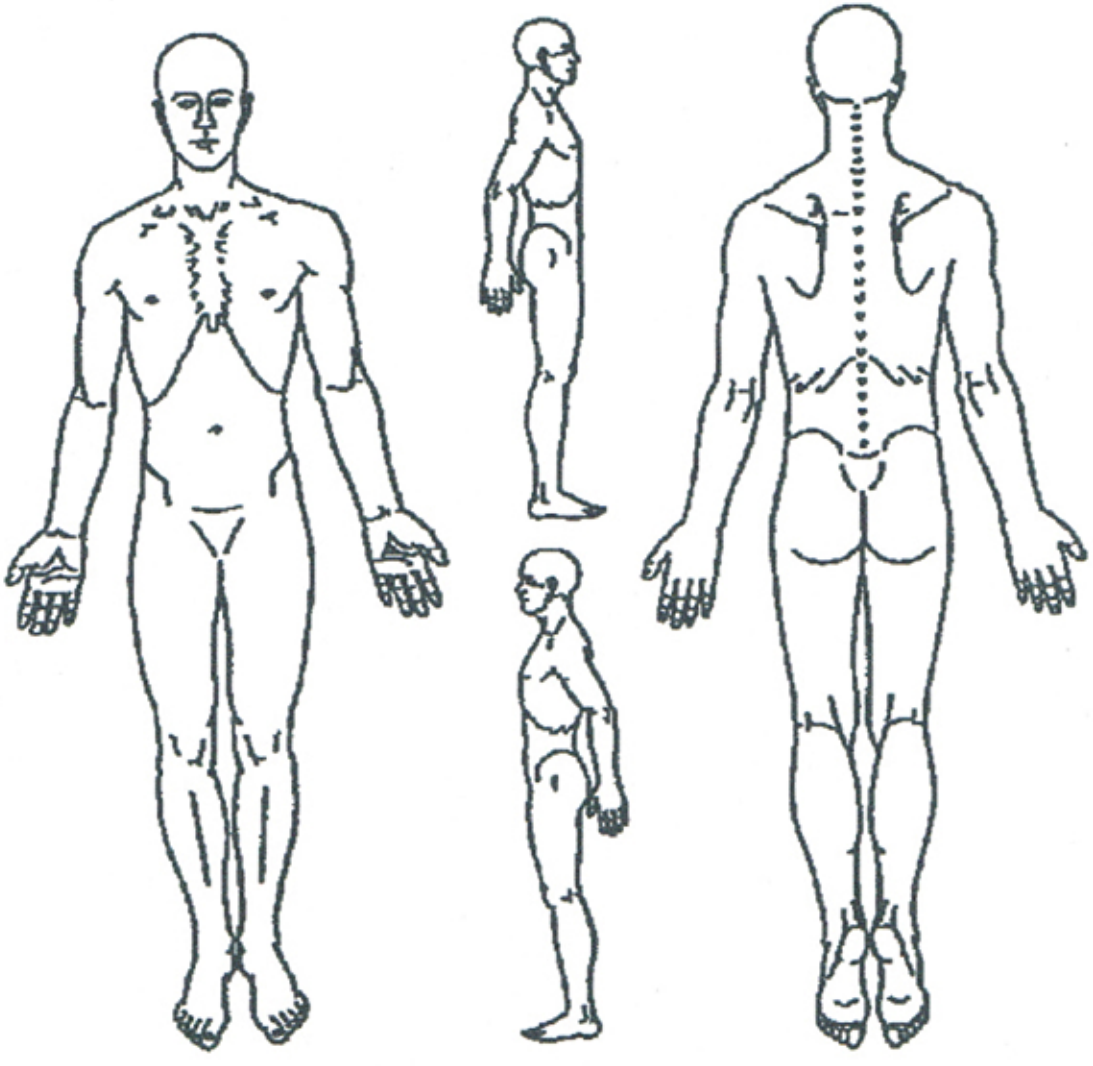
Pain (please describe)_____

Other Comments_____

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

PATIENT QUESTIONAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____ Phone Number_____

Name_____ Phone Number_____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL":

YES_____ NO_____

V. Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:_____

VI. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail?

YES_____ NO_____

PATIENT NAME_____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Patient Information sheet before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA.

Regarding Insurance

Please verify your benefits through your provider prior to treatment. If for any reason you are not able to, we will do so as a courtesy. You will be charged for each treatment until verification is obtained. Our fees are determined by the complexity of the particular case and the different services used during treatment. Any balance due on your treatments is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you bring in all insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. In the event we do not accept assignment of benefits we require that you provide a credit card number with authorization to bill that account for any balance your insurance company does not pay. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to your credit card. In signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally in signing this document you authorize the release of any information to any insurance company, adjustor or attorney that will assist in the payment of a claim.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services provided may be "non-covered" services and not considered reasonable and necessary under the Medicare program and/or by other medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

Thank you for understanding our financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

A photocopy of this form shall be considered as effective as the original.

X_____DATE_____

Signature of Patient or Responsible Party

NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by:_____

Printed Name - Patient or Representative

_____

Signature

Relationship to Patient (if other than patient):_____

Date:__/__/____

Witness _____

Printed name - Practice representative

Date:__/__/____

To: Patients Paying at the Time of Service

In an effort to minimize costs and create the best possible atmosphere for healing, we have made the following adjustments to our Usual and Customary Rates. Paying at time of service frees the office from time-consuming paper work and tracking of filed insurance claims.

At the time of your initial visit you will only be responsible for the New Patient office visit fee. Office visits and insurance rates are subject to change without notice. There are several procedures that may occur during your visit, which will be modified, any of the procedures used during your treatment will be reduced to $0.00.

97810-52 Acupuncture 1st 15 min	97813-52 Acupuncture w/Elec.stim 1st 15 min
97811-52 Acupuncture 2nd 15 min	97814-52 Acupuncture w/Elec.stim 2nd 15 min
97010-52 Heat Therapy	97140-52 Manual Therapy
97014-52 Elec.stim (unattended)	97530-52 Kinetic Activities
97032-52 Elec.stim (attended)	97110-52 Therapeutic Exercises
99070-52 Needles	

The fee for the New Patient off visit (code 99203) is $110.00

The fee for each office visit after the initial visit (code 99213) is $65.00

I have read and understand the information contained therein.

_____Date_____

Patient's Signature