PORT ORANGE
ACUPUNCTURE
HOLISTIC HEALTH
PORTORANGEACUPUNCTURE.COM
386.761.8818
Located in Spruce Creek Fly-In
100 Cessna Blvd - Suite B Port Orange, FL 32128

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.

Patient Name: _____ Date: _____

Date of birth (month/date/year):_____ Patients biological gender: _____Marital Status: _____

Patients address: _____ City/State/Zip: _____

Best number to reach you: _____ Reminder calls: Yes or NO

Email _____ Height (in feet and inches): _____ Weight (in lbs): _____

How did you first learn about our office: _____

Chief complaint: What changes are you seeking in your condition?

_____

Please list herbal, vitamin, mineral or other type of non-medications supplements:

_____

_____

Please list current medication or provide a copy of your Rx to the office : Medication name, dosage & frequency:_____

_____

Please list environmental, food based, medication and any other known allergies:

_____

_____

Please list surgeries (when and what type):_____

_____

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. **Please provide insurance card.**

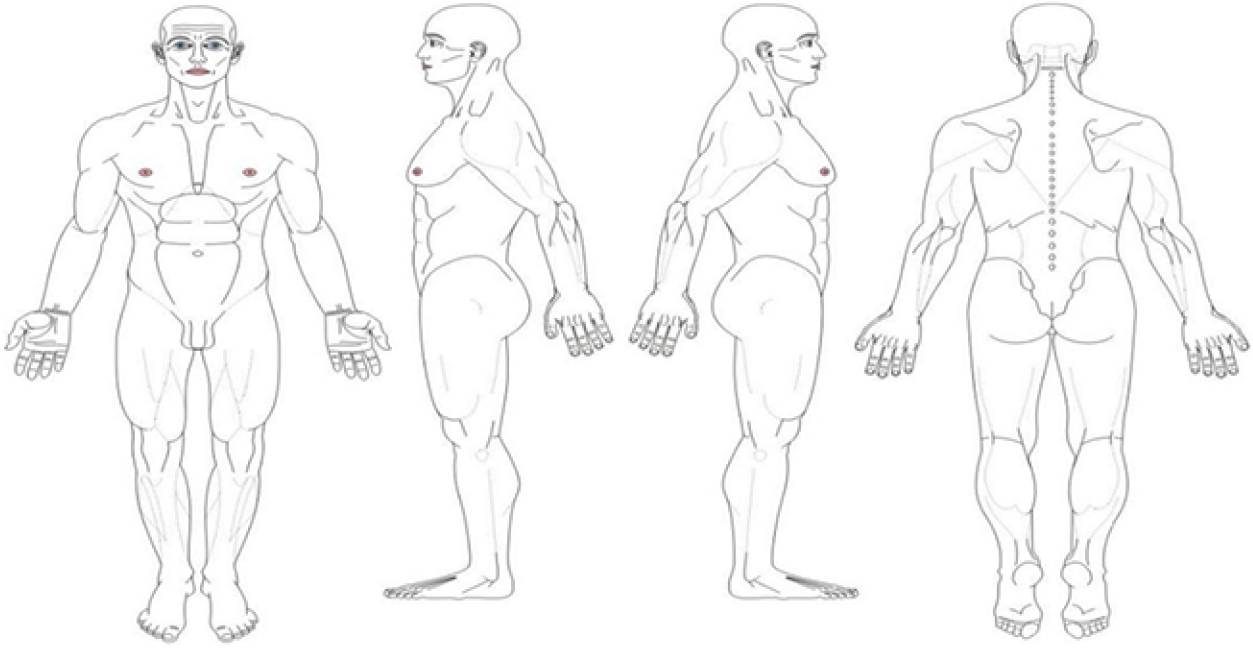
IN NETWORK: United Healthcare_____ CIGNA PPO ___ OUT OF NETWORK: BCBS____ AETNA___

PATIENT PROFILE

Name: _____ Date: _____

Do you or have you experienced any of the following?

- ☐ Chest pain
- ☐ Heart palpitations or flutters
- ☐ Anxiety
- ☐ Depression
- ☐ Panic attacks
- ☐ Fainting or dizziness
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Bleeding or clotting disorders
- ☐ History of epilepsy
- ☐ History of stroke, aneurysm, heart attack, blood clots or blocked arteries
- ☐ Shortness of breath
- ☐ Cancer
- ☐ Chronic viral infection
- ☐ Suppressed immune function
- ☐ Acid reflux or GERD
- ☐ Auto immune disorder
- ☐ Thyroid imbalance
- ☐ No, I'm good



Please indicate the level of pain you are experiencing

0 1 2 3 4 5 6 7 8 9 10

No pain **Severe pain**

Use the KEY below to indicate the type of pain, location of pain, and sensation of pain on the Figures above.

Ache=A Burn=B Throbbing=T Sharp/Stabbing=S Numbness=N Pins/Needles=PN Other= O

Head, ears, eyes, nose, throat:

Do you have any problems with loss of hearing, sense of taste, sense of smell, or vision? __Yes __No
If yes, please explain: _____

Cardiovascular:

Do you have any problems with chest pain, shortness of breath, asthma, high blood pressure, other?
__Yes__No If yes, please explain: _____

Gastrointestinal:

Do you have any problems with nausea, vomiting, constipation, diarrhea, blood in the stool, other?
__Yes __No If yes, please explain: _____

Genitourinary:

Do you have any problems with blood in the urine, pain or burning when urinating, exposure to sexually transmitted diseases, or other? __ Yes __No If yes, please explain: _____

Previous genitourinary tract history: FEMALES ONLY

First day of last menstrual period: mm/dd/yy _____ Number of pregnancies: ___ Number of miscarriages: ___ Number of abortions:___ Number of living children ___

Month and year of last breast examination by a physician: mm/yy _____ were the results normal?
___Yes ___No

Month and year of last mammography: mm/yy: _____ were the results normal? ___Yes ___No

Month and year of last CA-125 ovarian screen (blood test) mm/yy: _____were the results normal?
___Yes ___No

Previous genitourinary tract history: MALES ONLY

Month and year of last DRE (digital rectal examination, prostate examination) mm/yy: _____ were the results normal? ___Yes ___ No

Month and year of last PSA (prostatic specific antigen) mm/yy: _____ were the results normal?
___Yes ___ No

Musculoskeletal:

Do you have any problems with joints, ligaments, muscles, bones, serious injuries, other? __Yes __ No
If yes, please explain: _____

_____

Neuropsychiatric:

Have you ever attempted suicide or do you have thoughts of suicide? __Yes __ No If yes, please explain: _____

_____

Have you ever used tranquilizers or antidepressants? ___ Yes ___ No If yes, please explain: _____

_____

Have you ever been knocked unconscious or had a spinal injury? ___Yes ___No If yes, please explain details: _____

_____

Have you had any other problems with your nervous system or have you had any other psychiatric problems? ___Yes ___ No If yes, please explain: _____

_____

Endocrine:

Have you ever had problems with blood sugar, thyroid gland, or other glandular problems? __ Yes ____ No If yes, please explain: _____

_____

Have you lost or gained weight in the past year? If yes, how much? Lost_____ Gained_____

Skin:

Have you ever had skin cancer, moles, warts, or other lesions removed, or other skin problems? __ Yes ___No If yes, please explain: _____

_____

Blood & Lymphatic:

Have you ever had any circulatory problems or problems with your lymphatic system? __Yes ___ No
If yes, please explain: _____

Diet & Lifestyle:

Are you on any special diet? ___ Yes ___ No If yes, please explain: _____
_____

Please indicate your social history, and any HABITS/EXCESSIVE USAGE: (Please tell us how often & how much)

- ☐ Alcohol ___/per day
- ☐ Artificial sweetener___/per day
- ☐ Chocolate ___/per day
- ☐ Cigarettes ___/per day
- ☐ Coffee ___/per day
- ☐ Soda ___/per day
- ☐ Recreational drugs ___/per day
- ☐ Exercise ___/per day
- ☐ Food ___/per day
- ☐ Salt ___/per day
- ☐ Sex ___/per day, week, month
- ☐ Sugar ___/per day
- ☐ Tea___/per day
- ☐ Water___/oz per day

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:

a. Name _____ Phone Number _____

b. 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. 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 acupuncturist.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, MASTERCARD, VISA, AND AMERICAN EXPRESS.

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 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 the 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 canceled 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 acupuncturist's guidelines and stick with your treatment schedule. Please help us to service 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 the 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 (HIPPA).

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.

The Consent was signed by: _____

Printed Name-Patient or Representative Signature

Relationship to Patient (if other than patient): _____

Date: ___/___/___

Witness:_____

Printed name- Practice Representative

Date: __/__/___

ACUPUNCTURE INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working for associated with or serving as backup for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness, or tingling near the needling sites that may last for a few days, dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage, and organ puncturing (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomach ache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member or who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand that the clinical and administrative staff may review my patient records and lab reports, but all records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had the opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for my future condition(s) for which I seek treatment.

Patient Signature: _____ Date: _____

(Or patient representative if signing for patient): _____

Assumption of the Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people.

Port Orange Acupuncture has put in place preventative measures to reduce the spread of COVID-19; however, Port Orange Acupuncture cannot guarantee that you will not become infected with COVID-19 or that you are not already an asymptomatic carrier of COVID-19. Further, receiving services at Port Orange Acupuncture could increase your risk of contracting COVID-19.

By signing this agreement, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving services at Port Orange Acupuncture, and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 at Port Orange Acupuncture may result from the actions, omissions, or negligence of myself and others, including, but not limited to, Port Orange Acupuncture owners and employees.

In consideration for being permitted to receive services at Port Orange Acupuncture, I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself (including, but not limited to, personal injury, disability, and death), illness, damage, loss, claim, liability, or expense, of any kind, that I may experience or incur in connection with receiving services at Port Orange Acupuncture. On my behalf, and on behalf of my heirs, executors, administrators, personal representatives, and assigns, I hereby release, covenant not to sue, discharge, and hold harmless Port Orange Acupuncture, its employees, agents, and representatives, of and from any claims, including all liabilities, claims, actions, damages, costs or expenses of any kind arising out of or relating thereto. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of Port Orange Acupuncture, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after receiving services at Port Orange Acupuncture.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Print Name