

Acupuncture Gateway Health History Questionnaire

Date: _____

Please help us provide you with a complete evaluation by taking the time to complete this questionnaire carefully. All of your answers and remarks are kept confidential. If there is anything you wish to bring to my attention which is not asked here, please write in the comments section. THANK YOU VERY MUCH!. (Please write legibly.)

Name: _____ Date of Birth: _____ Gender: M ___ F ___
Phone: (Home/cell): _____ (Work): _____
Address: _____
City: _____ State: _____ Zip: _____
E-Mail: _____ SS#: _____ DL# _____

Would you like to receive our e-newsletter with supportive health information (only once per season)? Y/N

Insurance

Subscriber's Name: _____ Date of Birth: _____
Company Name: _____ ID#: _____

Auto Accident

Date of Accident: _____ Claim #: _____
Adjuster's Name: _____ Phone: _____

Height: _____ Weight: _____ Marital Status: _____

Emergency Contact: _____ Phone: _____

Whom may we thank for referring you? _____

Have you been treated by Acupuncture or Chinese Herbal Medicine before? Yes ___ No ___

By Who? _____

Main problem(s) you would like me to help with: _____

How long have you had this condition? _____

What was the cause or reason of current condition, if you can think of any? _____

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc?) _____

Symptoms are relieved by: _____

Symptoms are made worse by: _____

Have you been given any diagnosis by any physician? If yes, please write:

What kind of treatment have you tried for this problem? _____

Did this treatment work? _____

Please check all of these conditions that apply to you:

AIDS/HIV Cancer Lyme Disease Seizures High Blood Pressure
 Alcoholism Diabetes Multiple Sclerosis Tuberculosis Thyroid Disorder
 Allergies Emphysema Pacemaker Asthma Heart Disease Polio
 Lymph Nodes removed Birth Trauma Hepatitis A/B/C Rheumatic Fever
 Herpes I / II Scarlet Fever Epstein Bar Virus Mononucleosis
 Cyclo Megla Virus Prosthetics Implants, Other: _____
Surgeries or significant dental work (type of and date): _____

Birth history (prolonged labor, forceps delivery, etc.) _____

Allergies (drugs, chemicals, foods/result): _____

Family medical history (check):

Diabetes Cancer High blood pressure Heart disease Stroke Seizures
 Asthma Allergies, Other _____

Significant trauma (auto accident, falls, loss of family etc. / date): _____

Medications, Herbs, Supplements (List those you have taken in the last 2 months):

Name	Reason	How long and Dose
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you exercise regularly? Yes No If yes, what and how often a week: _____

Have you ever been on a restricted diet? If yes, what and how long? _____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Snacks _____

Special diet _____ 3 worst foods you eat _____

Smoke cigarettes? Y/N How much? _____

Smoke cigarettes in the past? Y/N How many years? _____ How many packs? _____

How often do you have?

Sugar/Sweet: _____ day/wk. Dairy (milk, cheese, yogurt): _____ day/wk.

Wheat (wheat products): _____ day/wk. Alcohol: _____ day/wk

How many cups/glasses do you have daily?: Water: _____ Soda: _____ Coffee ___ Tea: _____

Use marijuana? Y/N Smoked? Y/N Other? _____

Use recreational drugs? Y/N What and how often? _____

Have an addiction? Y/N To what and how long? _____

Been outside the U.S. in past 12 months? Y/N Where? _____

Are you always thirsty?: Yes: _____ No: _____ Do you prefer drinks hot/cold?

Rate your taste preference 1 to 5 (1-like most to 5-dislike, use each number once):

Salty: _____ Sour: _____ Bitter: _____ Spicy: _____ Sweet: _____

Treatment Terms and Conditions

The following are specific policies that will govern our work together:

Cancellation Policy

In the event that you must cancel an appointment, please give us the courtesy of as much notice as you can, but at least 24 notice. We will try to reschedule your appointment for the same week so that you don't miss your treatment. You will be charged \$25 if you do not show up for your appointment or cancel your appointment with less than 24 hours notice (1 full day).

Late Policy

If you are going to be late, please call and let us know and we will wait until the time we agree upon. If you do not give notice, we will wait 15 minutes beyond the start time of your appointment. If you have not arrived by then your appointment will be cancelled and you will be responsible for the \$25 late notice charge.

Phone Calls and Emails

You may phone or email us when necessary and we will respond as soon as possible, or within 24 hours. We are generally unavailable Sunday and Monday. Except for emergencies, phone and email contacts are limited to 10 minutes of our time. All contacts that require beyond 10 minutes of our time are considered session work and will be billed a flat rate of \$35.

Confidentiality and Privacy Practices

As a health care provider, we are required by law to maintain and protect the confidentiality of your health information. You must give us written consent to waive this confidentiality. Exceptions to this rule are strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, law enforcement activities, obtaining payment from third-party payers, and in consultation with other healthcare professionals. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent. Your rights to privacy regarding your protected health information:

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.

Please note that we may contact you for appointment reminders, birthdays & seasonal greetings, announcements and to inform you about our practice and its staff. A more complete description of our privacy practices can be requested.

Fees

It is our policy that you pay the entire session fee or co-pay at the time of each session. If you would like to arrange another payment option, please discuss it with us. We will provide a minimum of one month's notice of any changes to our fees.

We are partners in your healthcare.

Your participation in your healing process is crucial. Our goal is to get you well as soon as possible, which requires that you apply our health recommendations and comply with our treatment plan.

Agreement

I have read and understood the clinic's policies. I agree to the all of the above treatment terms and conditions.

Signature: _____ Date: _____

Informed Consent & Disclosure

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, herbal medicine, moxibustion, cupping, electrical stimulation, medical qigong, massage, gua sha, heat therapy, ear seeds, dietary advice, qigong exercise, prescriptions, and lifestyle counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Very unusual risks of acupuncture include dizziness, fainting, nerve damage, or pneumothorax. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential but unlikely risks of moxibustion are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha.

I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I also understand that certain social habits and medications may decrease the beneficial effects of Chinese medical treatment. These include the use and abuse of alcohol, pain killers, steroids, narcotics, tobacco, anti-depressants, and illegal drugs.

Acupuncture is a natural medicine that works with the body's ability to heal itself, but is not a substitute for conventional medical diagnosis and treatment. The results of acupuncture are not always felt immediately, especially with chronic conditions. Frequent, regular treatment is what gives acupuncture and herbs the best results.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice. I also certify that I have informed my acupuncturist of all known physical, mental and medical conditions and medications, and I will keep him updated on any changes.

Patient Signature

Date

Acupuncture Gateway Fee Schedule

Welcome to our office! The information below is provided to make you aware that our fees are different if you are a cash paying patient versus if you have insurance, or a personal injury (auto accident).

Insurance Patients: You will be responsible for payment of any deductibles, co-pays, and co-insurance amounts not covered by your insurance provider (the amount of these costs varies). Please note that we usually charge insurance companies between \$150-350 per visit, dependent on the therapies performed in conjunction with the acupuncture, such as: manual therapy (massage), infrared, e-stim, moxibustion, therapeutic exercises, etc. Charges are often higher for new patient visits or re-evaluations of your case. We rarely receive what we bill since all charges are reviewed and reduced by insurance companies. When you receive your explanation of billing (EOB) from your insurance company, it may tell you that you owe Acupuncture Gateway the difference between what we charged for your visit and what your insurance actually paid. This is not necessarily the case. We will inform you if we will need to collect this balance or a portion of it (we usually do not).

There may be times when our billing service is mis-quoted information and payment is not made as initially described by your insurance. These additional amounts are your responsibility and we will do our best to keep you apprised of any information regarding your benefits if they should change. Feel free to contact us any time if you have questions about billing your insurance for acupuncture.

Cash Patients: Currently our cash rate for a new patient visit (thorough exam, treatment, and report of findings) is \$95 and follow-up acupuncture visits are \$85.

These fees are called "point of service fees" as they are paid at the time services are delivered. Understand that this is also a discounted fee because it does not involve the administration and processing of insurance, and because we know most people are unable to pay our regular fees that we bill insurance companies. Since this is a discounted rate off of our usual fees, if, at any time, you have any other coverage either through insurance, an auto accident, or worker's compensation claim, please notify our office immediately so that we can make efforts to receive our regular rates.

Personal Injury (car accident) Cases:

Patients are not usually responsible for any costs associated with a personal injury claim with the exception of herbs/supplements. Please speak directly with our billing service about your case and provide your adjuster's information. The fees charged are our standard rates for third-party payers, which are dependent on the therapies you receive with your treatment. If for any reason we are denied payment, you will be responsible for payment on the account (a plan that works with your budget can be devised).

All fees charged at Acupuncture Gateway are reasonable and in keeping with industry standards.

Other Services:

- Herbal and Dietary consultations (includes a prescription for an herbal formula or specific dietary program); 30 minutes for \$55.
- Detox Acupuncture Treatments (for quitting smoking, alcohol, caffeine, sugar, weight loss); 30 minutes for \$45 or inquire about our package plan.

Herbal and Nutritional Supplements are NOT covered by insurance or third party payers and must be paid at the time these items are received.

I have read and understood the fees charged at Acupuncture Gateway.

Patient Signature

Date