PATIENT INFORMATION

–CONFIDENTIAL–

Name_____ Date of Birth ____/_____/_____ Occupation_____

Address_____ City_____Zip_____

☎Home (_____)_____ Work (____)_____ Cell (____)_____

Email :_____ ☐ I would like to receive your newsletter

Primary Physician _____ Social Security # _____ - _____ - _____

Emergency Contact: ☎_____ Name _____

Condition(s) for which you are seeking treatment: _____
_____
_____

When (and how) did this condition start? _____
_____
_____

Have you had this condition assessed by a medical doctor?_____
What was the diagnosis?_____

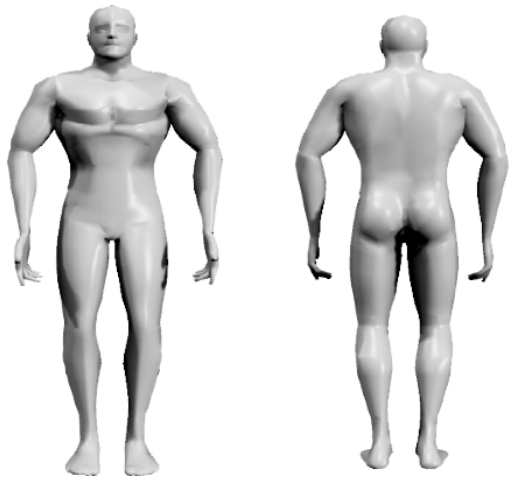
Other treatment you have had for this condition: _____
Has anything helped?_____

Are there other health issues that you would like to address? _____
_____

List all medications or dietary supplements that you are taking and why you take them:
_____
_____
_____
_____
_____
_____

List any major injuries, traumas, or surgeries and when each occurred:
_____
_____
_____
_____

Circle any places on your body that you feel pain or discomfort and describe the type of sensation (stabbing, burning, sharp, etc). ⏩



Please read carefully and indicate with check marks if you experience any of the following:

- ☐ Fatigue, tiredness
- ☐ Wheezing or difficult breathing
- ☐ Feel worse after exertion
- ☐ Spontaneous sweating
- ☐ Low appetite
- ☐ Loose stools
- ☐ Heart palpitations
- ☐ Frequent urination
- ☐ Prolapsed organs
- ☐ Catch cold often
- ☐ Bruise easily
- ☐ Get up at night to urinate
- ☐ Generally feel cold
- ☐ Cold feet
- ☐ Cold hands
- ☐ No thirst
- ☐ Low back pain
- ☐ Knee pain
- ☐ Edema
- ☐ Hearing loss
- ☐ Morning diarrhea
- ☐ Water retention
- ☐ Hot flashes
- ☐ Heat sensation in palms, soles
- ☐ Feel hot in afternoon / evening
- ☐ Night sweats
- ☐ Frequent thirst
- ☐ Difficulty falling asleep
- ☐ Ringing in the ears
- ☐ Low-grade fever
- ☐ Dry throat at night
- ☐ Anxiety
- ☐ Facial flushing

- ☐ Abdominal masses
- ☐ Distending pain
- ☐ Pain in ribcage
- ☐ Frequent belching
- ☐ Feel "wound-up"
- ☐ Muscular tension
- ☐ Depression
- ☐ Tension Headaches
- ☐ Blurred vision
- ☐ Dry hair
- ☐ Dry skin
- ☐ Poor memory
- ☐ Numbness
- ☐ Dizziness
- ☐ Waking at night

Have you ever been diagnosed with any of the following:

- ☐ AIDS or HIV
- ☐ Hemophilia
- ☐ Hepatitis Type_____
- ☐ Diabetes Type_____
- ☐ Cancer Type_____

Do you currently or have you in the past regularly used:

Tobacco?_____ How much?_____ How Long?_____
Alcohol?_____ How much?_____ How Often?_____
Coffee?_____ # Cups a day_____ How Long?_____
Soda Pop?_____# Per day?_____
Recreational Drugs? _____ Type? _____ How Long?_____

(Women Only) Is there a possibility that you may be pregnant? **Yes** **No** (circle one)

☐ PMS Bloating, tenderness, or irritability ☐ Cramping ☐ Scanty menses ☐ Heavy Menses
☐ Short Cycle ☐ Long Cycle ☐ Irregular Cycle ☐ Spotting ☐ Vaginal Discharge

Patient Information + Office Policies

Acupuncture and Chinese Medicine work to alleviate symptoms and correct constitutional imbalances at the root level. With this approach, patients find that multiple symptoms begin to improve simultaneously. This is a different approach than only trying to suppress symptoms, as is often the case with modern medicine. In addition, many patients feel more energetic, sleep better, experience improved digestion, and increased feelings of wellbeing when receiving regular acupuncture treatments.

Frequency of Treatment

Acupuncture is most effective when done in a series of regular, consistent treatments. Good, steady progress can usually be made with a **frequency of one treatment per week**. In some cases more frequent treatment may be recommended. After symptoms have disappeared, a less frequent "maintenance" level of treatment may be recommended.

Acupuncture is very safe. However, on rare occasions, adverse reactions can occur. These may include local bruising, pain or skin irritation at the needle insertion sight, light-headedness or temporary fatigue following treatment. Sometimes there will be a temporary aggravation of symptoms following a treatment. This "healing reaction" generally lasts 24-48 hours and is usually followed by an abrupt improvement in symptoms. **Only sterile, single-use disposable needles are used. Needles are never re-used.**

Chinese herbs are natural products, offering an effective and safe alternative to many drug treatments. Most Chinese herbs have been used safely for hundreds of years. All of our herbal products come from companies that do extensive testing to assure safety and non-contamination. Rarely, a patient may have a mild reaction to an herbal formula (the most common being mild indigestion). **Should any adverse reactions occur, you should stop taking the product and call us.**

Payment is due at time of service. We accept personal checks, cash and credit cards. We may be able to bill your insurance if you have coverage. Many insurance policies cover acupuncture. You are responsible to pay for your treatment until we receive verification of coverage from your insurance company. If we are not able to bill your insurance directly, we will provide you with a "superbill" that you may send to your insurance company for direct reimbursement.

Missed Appointment Policy

Please keep your appointments. If you are unable to keep your appointment, please call at least **24 hours** in advance to avoid a **no show/late cancellation fee.**

I have read, understand, and agree to the above.

X_____ **Date**_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by **Scott Evans, D.O.M., L.Ac.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Acupuncture of Lodi.**

I understand that diagnosis or treatment of me by **Scott Evans, D.O.M., L.Ac** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Scott Evans, D.O.M., L.Ac** is not required to agree to the restrictions that I may request. However, if **Scott Evans, D.O.M., L.Ac** agrees to a restriction that I request, the restriction is binding on **Scott Evans, D.O.M., L.Ac.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Scott Evans, D.O.M., L.Ac** have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Scott Evans, D.O.M., L.Ac**'s Notice of Privacy Practices prior to signing this document. **Scott Evans, D.O.M., L.Ac**.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Scott Evans, D.O.M., L.Ac.**

The Notice of Privacy Practices for **Scott Evans, D.O.M., L.Ac.** is also provided **At the office of Acupuncture of Lodi, 755 So. Fairmont Ave, Ste. B, Lodi, CA 95240**.

This Notice of Privacy Practices also describes my rights and the **Scott Evans, D.O.M., L.Ac.'s** duties with respect to my protected health information.

Scott Evans, D.O.M., L.Ac reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of **Acupuncture of Lodi @ (209) 339-9888** and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Name of Patient or Personal Representative

_____

Date

_____

Description of Personal Representative's Authority

Scott Evans L.Ac.
755 So. Fairmont Ave. Suite B
Lodi, CA 95240

FINANCIAL HARDSHIP WAIVER

I, _____, have expressed financial hardship to Scott Evans. Due to my financial circumstances I accept the payment plan below. The payment arrangements will be paid in full at time services are rendered. Delinquent payments may result in termination of this contract. If at any time my financial status changes, I will notify Scott Evans immediately and resume the usual and customary rates as designated by my insurance company and/or private pay rates. Scott Evans also holds the right to terminate this contract at any time, with prior notification, if breech of contract occurs.

Payment Arrangement

Evaluation + 1st acupuncture treatment = $80.00
Follow-up treatments = $65.00

_____ _____
Patient Name Date

_____
Patient Signature

Scott Evans' authorized representative agrees the above statement to be true and binding.

_____ _____
Witness Name Date

_____
Witness Signature