


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: _____

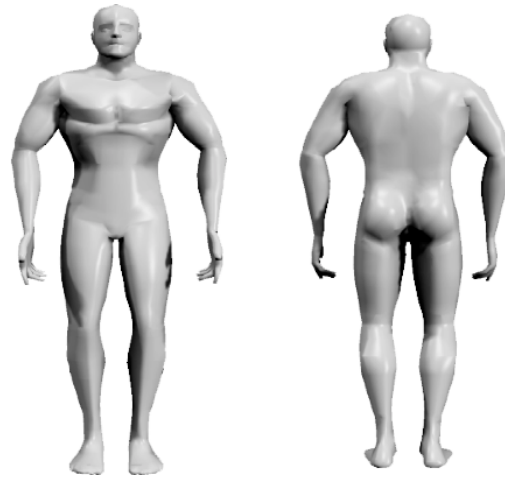
Has anything helped? _____

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:

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

- | | |
|--|--|
| <input type="checkbox"/> Abdominal masses | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Distending pain | <input type="checkbox"/> Dry hair |
| <input type="checkbox"/> Pain in ribcage | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Frequent belching | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Feel "wound-up" | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Muscular tension | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Waking at night |
| <input type="checkbox"/> Tension Headaches | |

Have you ever been diagnosed with any of the following:

- | | |
|--------------------------------------|-----------|
| <input type="checkbox"/> AIDS or HIV | |
| <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Hepatitis | Type_____ |
| <input type="checkbox"/> Diabetes | Type_____ |
| <input type="checkbox"/> 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)

- | | | | | |
|--|-------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> PMS Bloating, tenderness, or irritability | <input type="checkbox"/> Cramping | <input type="checkbox"/> Scanty menses | <input type="checkbox"/> Heavy Menses | |
| <input type="checkbox"/> Short Cycle | <input type="checkbox"/> Long Cycle | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Spotting | <input type="checkbox"/> 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, 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 **Scott Evans, L.Ac.**

I understand that diagnosis or treatment of me by **Scott Evans, 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, L.Ac.** is not required to agree to the restrictions that I may request. However, if **Scott Evans, L.Ac.** agrees to a restriction that I request, the restriction is binding on **Scott Evans, L.Ac.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Scott Evans, 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, 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, L.Ac.**

The Notice of Privacy Practices for **Scott Evans, L.Ac.** is also available at

The Centre for Structural Re-Integration, 7 Ross Ave., San Anselmo, CA 94960.

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

Scott Evans, 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 **Scott Evans, L.Ac. @ (415) 847-7767** 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 breach of contract occurs.

Payment Arrangement

Evaluation + 1st acupuncture treatment = \$125.00
Follow-up treatments = \$90.00

Patient Name

Date

Patient Signature

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

Witness Name

Date

Witness Signature