Humboldt Acupuncture Confidential Health Intake Form

Thank you for taking the time to complete the following information which better helps us to assess your care needs.

Patient's name: _____ Date:_____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Gender: M / F / T Phone: _____

Address_____City_____Zip_____ Email: _____

Insurance Plan _____ ID# or SSN_____

How did you hear about us? _____

What are your main health concerns?

1._____

2._____

3._____

Which of these health concerns has been diagnosed by a Medical Doctor? _____

_____

Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking:

_____

_____

Major injuries, surgeries and birth or labor trauma: ***(please include dates)***

_____

_____

_____

What are your treatment goals/expectations?

_____

_____

Is there any chance you are pregnant? Yes / No **Describe your menstruation cycle.** *(Length of flow and cycle, color of blood, etc.)*

_____

Do you have any infectious diseases? (*if yes which ones)*_____

List allergies: _____

What do you eat? (Average daily meals)

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

How often do you drink water?_____

Please circle any symptom you experience NOW, and *underline any that you have experienced in the PAST*:

Mental- Emotional: mood swings nervousness/anxiety obsessive thinking Depression poor memory Insomnia sadness worry anger mental fogginess Other:_____

Energy and Immunity: fatigue slow wound healing chronic infections Chronic Fatigue Syndrome night sweats lack of sweating unusual sweating (palms, soles, etc) Frequently catch colds Other:_____

Head, Eye, Ear, Nose, and Throat: Dizziness impaired vision eye pain/straining glaucoma glasses/contacts tearing/dryness impaired hearing ear ringing earaches ear infection headaches migraines sinus problems nose bleeds frequent sore throats teeth grinding TMD/jaw problems Hay Fever Strep Throat sore throat itchy throat sensation of something stuck in your throat excessive thirst Other: _____

Respiratory: difficulty breathing Emphysema/COPD Chronic cough Pleurisy Pneumonia Tuberculosis Asthma shortness of breath pneumothorax other respiratory problems: _____

Cardiovascular: Heart Disease chest pain swelling of ankles High Blood Pressure/ Low BP palpitations/fluttering stroke heart murmurs Rheumatic Fever Varicose Veins dizziness Other:_____

Gastrointestinal: Ulcers changes in appetite nausea/vomiting GI pain passing gas belching acid reflux Gall Bladder Disease Liver Disease Hepatitis Hemorrhoids constipation diarrhea Irritable Bowel Syndrome blood in stools polyps Pancreatitis Colon Cancer sweet cravings Other_____

Genito-Urinary Tract: Kidney Disease painful urination frequent UTI Frequent urination Kidney Stones Incontinence blood in urine Urination at Night difficult urination Kidney infections Other: _____

Female Reproductive/Breasts: pregnancies #_____ Births #_____ Irregular cycles Hysterectomy low libido breast lumps/tenderness nipple discharge vaginal discharge bleeding between cycles heavy / light flow menopausal symptoms difficulty conceiving painful period premenstrual Syndrome Endometriosis Other_____

Male Reproductive sexual difficulties prostate problems testicular pain/swelling penile discharge vasectomy infertility abnormal testing low libido Erectile Dysfunction Other_____

Musculoskeletal: neck/shoulder pain muscle spasms/cramps arm pain upper back pain mid-back pain low-back pain leg pain joint pain (if so, where?):_____ Other: _____

Neurologic: vertigo/dizziness paralysis numbness/tingling loss of balance seizures/epilepsy Other_____

Endocrine: Hypothyroid Hyperthyroid Hypoglycemia Diabetes Hot or Cold Obesity Other _____

Autoimmune and Inflammatory Conditions: Hashimoto's Disease Rheumatic Arthritis Fibromyalgia swollen glands Tendonitis Plantar Fasciitis Staph Infections Uveitis MRSA Psoriasis Eczema/Hives Other:_____

Other: Anemia Cancer rashes cold hands/feet Fungal infections Shingles bruise easily other _____

Lifestyle: regular exercise tobacco caffeine stress occupational hazards spiritual practice/community

Do you drink alcohol or use recreational drugs? _____ How often do you eat sugar?_____

Is there anything else we should know? _____

Jeffrey Haloff LAc MAcOM
Chelsea Colby LAc MAcOM

Patient Financial Responsibility Agreement

Patient Name:_____ **DOB:**_____

Please Initial next to your preferred payment method

Partnership Healthcare:

_____ Humboldt Acupuncture works closely with Partnership Health Plan of California (PHC) to provide services for those who receive PHC/Medi-cal insurance. Our facility follows all guidelines set forth by your PHC insurance provider. We will not ask for payment for approved treatment services that are covered by your health plan. PHC/Medi-cal patients will not be charged a missed appointment fee, but must agree to our cancellation policy of 24-48 business hrs notice for cancellations. ***Patients who violate the cancellation policy and have more than two "No shows" or "Same day cancellations" in a 3 month period could result in future scheduling restrictions.*** Signing this form gives Humboldt Acupuncture permission to bill your insurance provider on your behalf, and accept assignment of benefits.

VA or Private Insurance:

_____ Humboldt acupuncture participates with the VA or select private insurance companies. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf, by signing this form you agree to an assignment of benefits. Benefit payments will be made on your behalf directly to Humboldt Acupuncture. However, you are ultimately responsible for payment of your bill. You are responsible at the time of service for payment of any deductible and co-payment as determined by your contract with your insurance carrier. You are also responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue past your approved period, you will be responsible for your balance in full.

Self-Pay:

_____ I do not have health insurance at this time or Humboldt Acupuncture does not accept my current insurance plan. I will be responsible for services rendered here at Humboldt Acupuncture. I agree to pay the full amount of the treatment given to me, or to the above-named patient, at each visit. Humboldt Acupuncture will supply me with a super-bill receipt if I should want to submit my charges to my insurance company for reimbursement.

Our Cancellation Policy:

We understand that sometimes you have an emergency, need to cancel, or need to reschedule your appointments. If you are unable to keep your appointment, please notify us as soon as possible. When you miss your appointment, or cancel without 24hrs notice, we are unable to fill the empty appointment spot. This can result in unmanaged care for other patients. Partnership patients cannot exceed two same day cancels or no-show appointments in a 3 month period.

Fees for missed appointments:

There is a fee of $95.00 for appointments missed or cancelled without a 24-48-hour notice.

Humboldt Acupuncture appreciates the confidence you have shown in choosing us to provide for your health care needs. By signing below you acknowledge you have read the above policy regarding your financial responsibility for services in our facility, that you authorize your insurer to pay any benefits directly to Humboldt Acupuncture, and that you certify the information you provide is true and accurate.

Patient Signature_____**Date**_____

Guarantor Signature_____**DOB**_____

Jeffrey Haloff LAc MAcOM
Chelsea Colby LAc MAcOM

HIPPA Compliant Authorization Form

The following form is consent to the use and disclosure of health information by our facility for Treatment, Payment, or other healthcare operations.

Patient Name: _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care of treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereupon.

Primary Care Facility or Doctor: _____

I request the following restrictions to the use of disclosure of my health information:

_____

_____

_____

By signing below I acknowledge that I, or my legal Representative have received and agree to the Patient Privacy Rights of this practice:

Patient Signature_____**Date**_____

Guarantor Signature_____**DOB**_____

Jeffrey Haloff LAc MAcOM
Chelsea Colby LAc MAcOM

Patient Consent to Treatment Form

Treatment and Informed Consent Information

*** Acupuncture/Moxibustion:** I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain common side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. Less common more serious side effects early can occur including fainting, nerve damage, or organ puncture. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

*** Direct Moxibustion:** I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

*** Chinese Herbs:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call the Chinese Medical Clinic as soon as possible.*

*** Acupressure/Tui-Na Massage:** I understand that I may also be given acupressure/tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

*** Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

Upon signature I do hereby voluntarily give permission and consent to treatment in addition to the following,

I give consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the clinic of Humboldt Acupuncture. I understand that acupuncturists may not be primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners. I understand that there may be other treatment alternatives, including treatment offered by a licensed physician. I understand that all my medical information is confidential and I agree to inform my practitioner of any pregnancy, pacemaker, bleeding disorders, or medical conditions before treatment. I have carefully read and understand all of the above information and am fully aware of what I am signing. I release Humboldt Acupuncture and its providers from any liability related to the inherent risks of treatment. I understand that I may ask my practitioner for a more detailed explanation if needed.

Patient Signature_____**Date**_____

Guarantor Signature_____**DOB**_____

Jeffrey Haloff LAc MAcOM
Chelsea Colby LAc MAcOM

Illness Precaution and Policy Agreement

Our Commitment to Your Health and Safety

At Humboldt Acupuncture our priority is to maintain a safe and healthy environment for all patients and providers. While we follow strict hygiene and safety protocols to reduce the risk of illness transmission, we acknowledge that there is presently no way to ensure 100% protection from any pathogen. To minimize the risk of exposure to contagious conditions, we have established the following precautionary policies.

Illness and Contagious Conditions Policy

If you are experiencing symptoms of a contagious illness, we request that you call our office the **as soon as possible** to discuss your symptoms. This helps us protect our staff and other patients from possible exposure to infectious conditions. **Please note that Non-contagious illnesses do not require cancellation**

If you exhibit any of the symptoms below, we ask that you please reschedule your appointment:

Symptoms that may indicate a contagious condition include but are not limited to:

- *Fever of 100.4°F (38°C) or higher*
- *Persistent cough*
- *Sore throat with fever*
- *Difficulty breathing*
- *Vomiting or diarrhea within the past 24 hours*
- *Loss of taste or smell*

Cancellation and Missed Appointment Policy

We kindly ask 24-48 hours' notice for all cancellations, this is to ensure we can continue providing care for all of our patients. Our standard cancellation policy and/or missed appointment fees still apply to appointments canceled due to illness.

Informed Consent and Agreement

I acknowledge that I have read and understand the precautionary policies of Humboldt Acupuncture, I agree to follow these guidelines and accept the risks associated with in-person treatment. I understand that non-contagious illnesses do not require cancellation and that standard cancellation policies apply.

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Patient Info		(Office use only)
Name		Ins Year:
DOB		Acu Visits: # 2X MONTH with PHC ▯
Insurance		Coins/Copay: DED: $ Met: ▯
CIN/ ID		Auth/eRAF #:
Phone		AUTH ENDS:
Address		Notes:
Primary/ Pref Prov		

Visit #	Date	Visit Info and Billing date	Payment Rec.