**Acupuncture Center of Richmond**

|  |
| --- |
| Name Sex M F Date / / |
| Date of Birth Age Family Physician |
| Address: City State Zip |
| Email:  |
| Cell Phone # Home Phone # |
| In Emergency notify: Emergency contact # |
| Do you have Health Insurance? Yes No Name of Insurance Company: |
| Does your insurance cover acupuncture? Yes No Have you ever been treated by acupuncture before? |
| How did you hear about us? Friends/Relatives/Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other (please specify) |

**Main Problems:** Reason for coming in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this problem begin? What are the precipitating factors?

Have you been given a diagnosis for this problem? If so, what?

What kind of treatment have you tried?

What makes this problem worse? What makes this problem better?

What is your pain level today? (1-10)

Remarks and additional information:

**Past Medical History:**

Significant Illness:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Tuberculosis |  | Diabetes |  | Hemophilia |  | Emotional Imbalance |
|  | Hepatitis |  | Cancer |  | Anemia |  | Venereal Disease |
|  | HIV/AIDS |  | Hypertension |  | Arthritis |  | Digestive Disorders  |
|  | Seizures |  | Fibromyalgia  |  | Heart Disease |  | Breathing Problems  |

Month /Year when diagnosis was established:

Other significant illnesses:

Surgeries/Hospitalization:

Significant trauma (auto accidents, sports injuries, etc.):

**Family Medical History:** (please specify family member)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cancer | Diabetes | Hepatitis | Hypertension | Stroke |
| Asthma | Alcoholism | Miscarriage | Heart Disease | Fibromyalgia |
| Other:  |

**Medications:** including vitamins, over the counter medications, and herbs

**Personal:** Height \_\_\_\_\_\_ Weight \_\_\_\_\_\_ One year ago \_\_\_\_\_\_

 Maximum weight \_\_\_\_\_\_\_ @ year \_\_\_\_\_\_

**Habits:** Do you smoke? Yes No How much? \_\_\_\_\_\_\_\_\_\_ How long? \_\_\_\_\_\_

 Do you exercise regularly? Yes No

What type of exercise and how often?

Does exercise make the issue better? Yes No

Is the condition effecting your sleep?

**Diet:** How many alcoholic beverages do you consume in a week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How much water do you drink in a day? \_\_\_\_

Are you open to taking Chinese herbal formulations to augment your treatments?

**Please indicate painful or distressed areas with:**

**N**=Numbness **P**=Pins and Needles **S**= Stabbing Pain **A**= Achy **T**= Tightness



Do you have any bleeding disorders (hemophelia etc.)? Yes (specify) \_\_\_\_\_\_\_\_\_\_\_\_ No

Are you taking any blood thinners (coumadin etc.)? Yes (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No

Do you have any history of seizures or epilepsy? Yes No

If female: Are you pregnant or trying to conceive? Yes No

**Please check if you have had (in the last 3 months) any of the following diseases or conditions.**

**General**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Poor Appetite |  | Night Sweats |  | Poor Balance |  | Easily Bleed/Bruise |
|  | Poor Sleep  |  | Sweats Easily |  | Weight Loss/Gain |  | Desire Hot/Cold Foods |
|  | Fatigue |  | Tremors |  | Peculiar Tastes |  | Sudden Energy Drop |
|  | Fevers/Chills |  | Excessively Hungry |  | Strong Thirst |  | Dizziness |

**Musculoskeletal**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Joint Disorders |  | Cold Hands/Feet |  | Paralysis |  | Swelling of Hands/Feet |
|  | Muscle Weakness |  | Back Pain |  | Shoulder Pain |  | Difficulty Walking |
|  | Hand/Wrist Pain |  | Spinal Curvature |  | Cramping |  | Neck Tightness/Pain |
|  | Numbness |  | Hernia |  | Knee/Hip Pain |  | Whole Body Soreness |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other issues you want to discuss with us?

**I understand the above information and guarantee this form is completed to the best of my knowledge.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Adult Patient Spouse Parent/Guardian

Recommendation for Examination by a Physician

**Virginia law requires that I give this form to you if I do not have written evidence that you have received a diagnostic exam in the last six months from a licensed practitioner of medicine, osteopathy, chiropractic or podiatry regarding the condition for which you are seeking treatment. (*Code of Virginia* §54.1-2956.9, 18 VAC 85-110-10).**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acupuncturist Date

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, recommend to you

 (licensed acupuncturist)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ that you be examined by a

 (patient)

physician regarding the condition for which you are seeking acupuncture treatment.

I understand this recommendation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date

# Acupuncture Center of Richmond

## Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at this clinic of Chinese Medicine. I understand that acupuncturists practicing in the state of Virginia are not 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.

**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 adverse 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. 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.

**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.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGN BELOW *ONLY* IF YOU REQUESTED AND RECEIVED MORE DETAILED INFORMATION**

I requested and received, in substantial detail, further explanation of the procedure or treatment, other alternative procedures or methods of treatment, and information about the material risks of the procedure or treatment. I give my permission and consent to treatment.

*X*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *X*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Patient’s Signature Date Explained by me and signed in my presence Date

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION**

**FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

**NAME** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BIRTHDATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **SOCIAL SECURITY #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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.

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

**Patient: X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#  Patient Signature or Legal Representative Date Witness Signature

Office Use Only:

ٱ Accepted \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

ٱ Denied Signature Title Date

**Our Clinic Protects Your Health Information and Privacy**

This notice describes our office’s policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company¸ with Worker’s Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

***Safeguards in place at our office include:***

* + - Limited access to facilities where information is stored.
		- Policies and procedures for handling information.
		- Requirements for third parties to contractually comply with privacy laws.
		- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file.

***Types of information that we gather and use:***

In administering your health care, we gather and maintain information that may include non-public personal information.:

* + - About your financial transactions with us (billing transactions).
		- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners.
		- From health care providers, insurance companies, workman’s comp and your employer, and other third part administrators (*e.g*. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you - *e.g.* your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy. If you have questions about our privacy guidelines, please call us during regular business hours at (804) 754-5108.

The Acupuncturists of the Acupuncture Center of Richmond

**Acupuncture Center of Richmond Office Procedures**

***Appointments***

As a patient of the Acupuncture Center of Richmond (ACR), it will be your responsibility to keep scheduled appointments. The clinic will require notification of cancellation at least 24 hours prior to the appointment or earlier if possible. This can be done by calling our clinic at 804-754-5108**. Failure to cancel your appointment will result in being assessed an appointment fee of $90**. This fee is due when billed, or at your next appointment whichever comes first. In cases of extraordinary circumstances which do not allow you to give one-day advanced notice you still need to call as soon as you are able and inform ACR that you will be missing your appointment.

***Late Arrivals:***

If you arrive late to your appointment, you may be asked to reschedule or will still be required to pay the **full session fee** regardless of how much time is left of your scheduled appointment.

***Payment***

We accept checks, cash or credit cards. Payment is due at time of service.

***Insurance***

The ACR does not file insurance/health savings account/flex-spending account claims, if you plan on using one of those methods for reimbursement you will need to file the claims on your own. ACR will provide you with a receipt of services that can be used to complete the paperwork to submit to your insurance company.

***Outstanding debts/delinquent accounts***

Patients with outstanding account balances are denied services until all debts are paid in full.

***Late penalty***

Late fees are assessed at the time of billing for accounts that are 30 or more days past due. **At 30 days past due, a late penalty of 10% of the outstanding balance is assessed**. The late penalty indicates that your account is past due. Unless you resolve the debt, ACR will advance the matter to the next step in the collection process, and you risk tarnishing your credit rating.

***Collection Activities***

Once an account is **90 days past due and forwarded to collections**, repayment arrangements must be made directly with the collection agency, and the account holder bears the costs associated with the collection efforts. The costs associated with collection efforts are 33.33% of the outstanding balance, which is the standard and customary amount for the collection industry. I have read and understand the above document; by signing below I agree to adhere to the policies and procedures of the Acupuncture Center of Richmond.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_