pacific healing arts

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Name: Date:

Street Address: City: State: Zip:

Home Phone: Work Phone: Email:

Date of Birth: Age: Gender: Social Security Number:

Marital Status: Occupation:

Employer Name & Address:

Emergency Contact (Name & Phone):

Referred By:

Do you have health insurance? ☐ yes ☐ no Does it cover acupuncture or massage? ☐ yes ☐ no

*For **MINORS**, please list name(s) and address(es) of parents if different than above.*

*Please list the following information if the person responsible for payment is **NOT** the patient.*

Name: Relation to Patient:

Street Address: City: State: Zip:

Phone: Alternate Phone: Email:

HEALTH HISTORY

What are you primary health concerns?

Are you being treated elsewhere for these or other conditions? Please specify.

Are you currently taking any medications? Please list.

Are you currently taking any herbs, vitamins or supplements? Please list.

Are you allergic to any medications, herbs or supplements? Please list.

Have you had any surgeries or hospitalizations? Please list and explain.

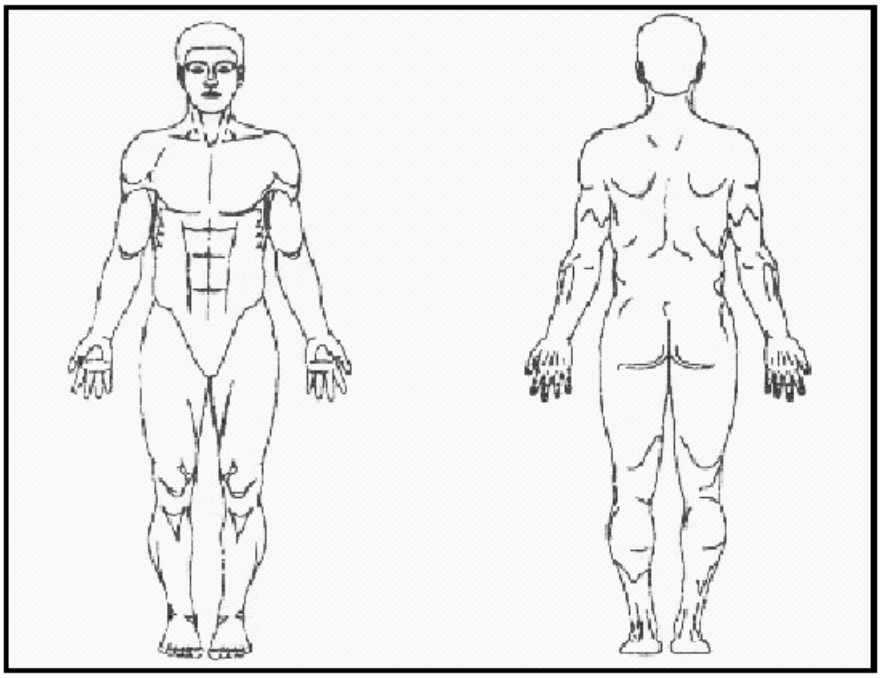
Please list any significant accidents, injuries or trauma. Please include date.

Are you pregnant? ☐ yes ☐ no ☐ maybe If yes, what week are you in the pregnancy?

Have you received acupuncture before? ☐ yes ☐ no

Current & Past Illnesses *(check all that apply)*

☐ hepatitis ☐ A ☐ B ☐ C	☐ tuberculosis	☐ thyroid disorder
☐ HIV/AIDS	☐ migraine headache	☐ hormonal disorder
☐ cancer	☐ epilepsy/seizures	☐ digestive disorder
☐ hemophilia/bleeding disorder	☐ insomnia	☐ food allergy or sensitivity
☐ heart disease	☐ mental illness	☐ kidney disease
☐ high blood pressure	☐ emotional problems	☐ sexually transmitted disease
☐ stroke	☐ alcoholism/drug dependence	☐ urinary disturbance
☐ high cholesterol	☐ parkinson's disease	☐ prostate disorder
☐ emphysema	☐ alzheimer's disease	☐ impotence
☐ asthma	☐ arthritis	☐ PMS, menstrual pain
☐ frequent common cold	☐ rheumatic fever	☐ irregular menses
☐ bronchitis/pneumonia	☐ anemia	☐ infertility
☐ allergies	☐ diabetes	other:



Please mark any areas where you have pain or discomfort on the diagram.

Which of the following is a part of your lifestyle? *(check all that apply)*

☐ tobacco/smoking	☐ alcohol	☐ coffee
☐ regular exercise	☐ stress	☐ cola/soda
☐ relaxation/meditation	☐ yoga/tai-chi/qi gong/other	

Are there any other health conditions you wish to mention?

Cancellations & Payment: We request 24 hour notice if you need to cancel your appointment. Cancellations under 24 hours are subject to a $75 charge except in the case of emergency. If we are billing your insurance you may be responsible for co-pays or unpaid balances. We accept payment in cash, check or credit card.

Privacy Policies: I consent to the use or disclosure of my identifiable health information by Pacific Healing Arts (PHA) for the purposes of diagnosis or providing treatment, obtaining payment for my health care bills or to conduct health care operations.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. I have the right to revoke this consent, in writing, at any time except to the extent that PHA has taken action in reliance on this consent.

I understand I have the right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations. The Notice of Privacy Practices is available at the front desk.

Informed Consent: I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or the patient for whom I am legally responsible) by Stephen Eggleston, Lee Holden or any acupuncturist associated with them or PHA. I understand that treatment methods may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, massage, and herbal medicine. I will immediately notify the acupuncturist of any unanticipated effects associated with the consumption of the herbs. I understand that some herbs may be inappropriate during pregnancy. I will notify the acupuncturist if I am or become pregnant. I have been informed that acupuncture is generally safe, but that it may have some side effects, including bruising, temporary tingling near the needling sites, and dizziness or fainting. Burns are a potential risk of moxibustion or when treatment involves the use of heat lamps. Bruising is a side effect of cupping. The clinic uses sterile disposable needles to minimize any risk of infection. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. I do not expect the acupuncturist to be able to anticipate and explain all risks and complications, and I wish to rely on the acupuncturist to exercise judgment during the course of treatment, which the acupuncturist feels based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Under-Insured Waiver (Applies only to payment by private insurance) I accept the following payment plan due to my level of insurance coverage. Delinquent payments may result in termination of this waiver. If, at any time, my insurance status changes I will give notification and resume the usual and customary rates as designated by my insurance company and/or private pay rates. PHA may terminate this waiver at any time with prior notification if there is breech of contract.

Payment Plan: If the insurance company does not pay for services rendered, for whatever reason, I accept the following payment arrangement: 1) I agree to pay for the exam and initial acupuncture insertion performed during my first consultation and treatment. 2) I agree to pay for the initial acupuncture insertion performed during all following visits. Any additional procedures performed will be billed to the insurance company and any patient responsibility for those modalities will be waived. Supplements, durable medical equipment and additional services noted by the provider do not apply to this payment arrangement.

I have read and understood the above policies. I certify all information entered to be true and correct to the best of my knowledge.

Patient Signature X: **Date:**