Southern Oregon Acupuncture

547 E Pine Street, Suite 201
Central Point, OR 97502

Phone : 541-200-2267
Fax : 541-423-8508

CONDITIONS OF SERVICES RENDERED

FINANCIAL AGREEMENT: I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Southern Oregon Acupuncture in accordance with the regular rates and terms. Late fees may occur when payments are not made on time. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees, and collection expenses. In addition, professional courtesies may be removed.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, whether I sign as agent or as patient, direct payment to Southern Oregon Acupuncture of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient services at a rate not to exceed Southern Oregon Acupuncture's actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

HEALTH PLAN OBLIGATIONS: Southern Oregon Acupuncture maintains a list of health plans with which it contracts. Southern Oregon Acupuncture has no contract, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Southern Oregon Acupuncture if he/she belongs to a plan, which does not appear on the above- mentioned list.

RELEASE OF INFORMATION: I authorize Southern Oregon Acupuncture to release any information necessary to provide medical treatment to me, allow Southern Oregon Acupuncture to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Southern Oregon Acupuncture is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

INSURANCE BENEFIT VERIFICATIONS: Southern Oregon Acupuncture will verify your insurance benefits as a courtesy. Verifications do not guarantee payment from your insurance company.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Southern Oregon Acupuncture. The undersigned certifies that he/she had read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE: _______________ PRINT NAME: _____________________________________

SIGNATURE: ____

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than patient, indicate relationship: _________________

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PATIENT ACKNOWLEDGEMENT FORM

Receipt of Joint Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of Southern Oregon Acupuncture's Notice of Privacy Practices. Southern Oregon Acupuncture is permitted to use or disclose my health information to carry out treatment, payment or health care operations. Health information means any and all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Southern Oregon Acupuncture's Notice of Privacy Practices explains the types of uses or disclosures that Southern Oregon Acupuncture may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Office Manager at the telephone number listed below. I further understand Southern Oregon Acupuncture may change the terms of the Notice of Privacy Practices from time to time, and that I may contact the Office Manager to obtain a revised version of the notice at any time.

Patient's Printed Name: ___________________________________ Patient's DOB: _____________

Signature of Patient: ____ Date: _______________

Signature other than patient: _____________________________________ Date: _______________

If signed by other than patient, indicate relationship: ______________________

You may contact our office regarding your privacy by calling 541-200-2267

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Patient Registration Form

Patient name ______________________________ Male ___ Female ___ Date of birth ____/____/____

SSN __________________________

Mailing address ____

City _______________ State ____ Zip ___________

Home Phone ____________________ Cell Phone ____________________

Email: ____

Single ___ Married ___ Divorced ___ Widowed ___

Employer ______________________________________ Phone _____________________

Is it okay to leave medical information on your voicemail if we are unable to reach you? Yes ___ No ___

Emergency Contact

Name _______________________________________ Relationship _____________

Phone _____________________

Spouse's name ___________________________________ Date of birth ____/____/____

Spouse's SSN _____________________ Phone _________________________

Spouse's Employer ____Phone ____________________

Medical Insurance Information

Primary Insurance ______________________ Subscriber Name ________________________________

Member ID # _____________________________ Subscriber DOB ____/____/____

Group # _____________________________

Secondary Insurance ______________________ Subscriber Name _____________________________

Member ID # _____________________________ Subscriber DOB ____/____/____

Group # _____________________________

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CONSENT TO TREAT

What is acupuncture?

Acupuncture is a form of therapy in which fine needles are inserted into specific points on the body.

Is acupuncture safe?

Acupuncture is generally very safe. Serious side effects are very rare.

Does acupuncture have side effects?

- You need to be aware that: drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive
- Minor bleeding or bruising may occur
- Pain during treatment can occur
- Symptoms can get worse after treatment
- Fainting can occur in certain patients, particularly at the first treatment
- In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you

Is there anything your practitioner needs to know?

Apart from the usual medical details, it is important that you let your practitioner know:

- If you have ever experienced a fit, faint or funny turn
- If you have a pacemaker or any other electrical implants
- If you have a bleeding disorder
- If you are taking anti-coagulants or any other medication
- If you have damaged heart valves or have any other particular risk of infection

Single-use, sterile, disposable needles are used in the clinic

The provider has explained to me the most likely complications of the possible undesired results of his/her examination and treatment, and I understand them. I authorize and direct the physician with associates or assistants to provide such additional services as they may deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ OR HAVE HAD READ TO ME THIS CONSENT FORM PRIOR TO MY SIGNATURE

Patient Name: ____

Patient's Signature: ____ Date: ________________

Signature of Parent/Guardian: ____ Date: ______________

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Acupuncture New Patient Paperwork

Patient Name: ____ DOB: ________________________________

What are your main health issues that you would like to address today?

____
____
____

What was the initial cause of your injuries or health issue?

____
____

How long have you had this/these conditions?

____

Is it getting worse? ___ Yes ___ No

Does it bother your: ___ Sleep ___ Work ___ Other ____

Are you trying or have you tried any other therapies to help this condition? ________________________

____

Have you had acupuncture before? ___ Yes ___ No

How about Chinese Medicine? ___ Yes ___ No

Please tell me a story of this condition(s): Use the back of the paper if necessary.

____
____
____
____
____
____
____
____
____
____

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Please include any of the following: Alcoholism, High blood pressure, Cancer, Diabetes, Heart disease, Osteoporosis, other addictions or illnesses:

Member__________Living______Important Disease_________Cause of Death______________Age___

Mother____

Father ____

Sibling ____

Sibling ____

Sibling ____

Grandparent ____

Grandparent ____

Current Health Care Providers:

Name: ______________________________ Date(s): _________________ Care Provided: _______________

Name: ______________________________ Date(s): _________________ Care Provided: _______________

Name: ______________________________ Date(s): _________________ Care Provided: _______________

Name: ______________________________ Date(s): _________________ Care Provided: _______________

Hospitalization/Surgery:

Date: ________ Hospital : ______________ Diagnosis/Operation:__________________Doctor:___________

Date: ________ Hospital : ______________ Diagnosis/Operation:__________________Doctor:___________

Date: ________ Hospital : ______________ Diagnosis/Operation:__________________Doctor:___________

Date: ________ Hospital : ______________ Diagnosis/Operation:__________________Doctor:___________

Date: ________ Hospital : ______________ Diagnosis/Operation:__________________Doctor:___________

Accidents/Injuries – Briefly Describe:

More than 5 yrs ago: ____

Less than 5 yrs ago: ____

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Have you ever been diagnosed with cancer, a mass, or tumor: ___ Yes ___ No

If so, Type? ______________________ Location? _______________________ Stage? __________________

Current Status? ____

____

Medications

(Please list all prescriptions and over the counter medications that you are currently using)

RX Name	What is it for?	How long?	Strength/Dose?	Frequency?

Supplements/Herbs

Were these recommended by: ___ A practitioner? ___ Self? ___ Both?

Supp/Herb Name	Brand Name	Potency (mgor IU, etc)	Dose	Frequency

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Current Personal Information

In general I feel my overall health is: ___ Excellent ___ Good ___ Fair ___ Poor

Mark the following: **1** if current **2** if past

	Asthma		Ringing in Ears		Palpitations		Migraines
	Bronchitis		Sciatica		Tightness in Chest		Headaches
	Pneumonia		Freq. Urination		Rheumatic Fever		Freq. Depression
	Freq. Cold/Flu		Dribbling Urine		Heart Problems		Jaundice
	Epstein Barr		Painful Urination		Poor Sleep		Hepatitis
	Chronic Fatigue		Scanty Urination		Hypoglycemia		Hemorrhoids
	Mononucleosis		Blood in Urine		Sever Mood Swings		Eye Problems
	HIV Positive		Prostate Problems		Diabetes		Photophobia
	AIDS		No/Low Sex Drive		Over Weight		Dizziness
	Allergies		ED		Under Weight		Stroke
	Sinus Congestion		Afternoon Hot Flash		Eating disorder		Varicose Veins
	Colitis		Night Sweats		Gum/Teeth Problem		Drug Addiction
	Chrons		Hearing Problems		Lots of fillings		Alcoholism
	Diverticulitis		Tinnitus		TMJ		Epilepsy
	Parasites		Memory Difficulties		Concussion		Frequent Anger
	Gas		Anxiety		Freq. Frustration		Bloating
	Arthritis		Heartburn/Indigest.				

Height __________ Weight __________ Blood Type __________

Please rate the following on a scale of 1-10 (10 being the best) & write in any comments:

Sleep? _____ Energy Level? ______ Appetite? _______ Digestion? ______

Any gas, bloating, or other discomfort after eating? ____ Yes ___ No

Elimination regular? ___ Yes ___ No

Bowels: ___ Float ___ Sink ___Bad Odor ___ No Odor ___ Blood Present

Do you rely on any of the following for bowel elimination?___ No ___ Yes, how often? ______________

___ Enemas ___ Laxatives ___ Purgatives ___ If yes, what brand? ________________________

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? If yes, please explain: _______

____

Any foreign residence or travel in the last two years? ____

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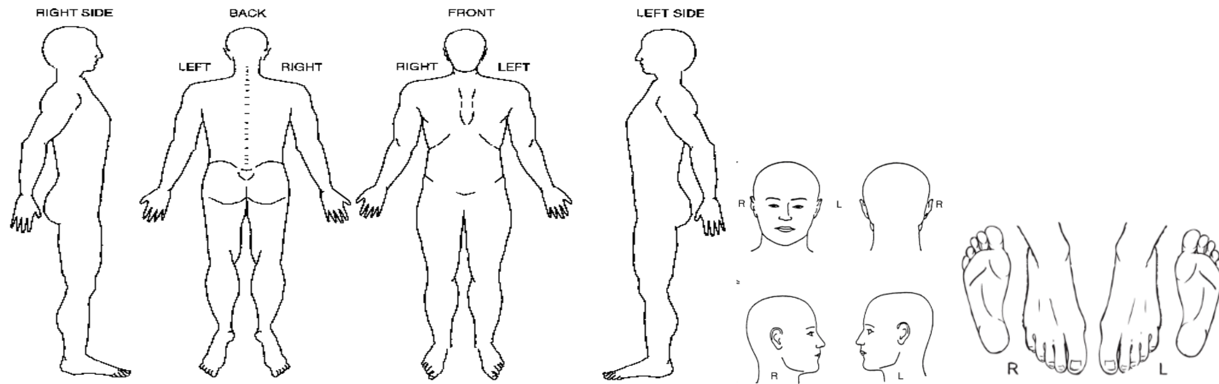
Pain: ___ Dull ___ Sharp ___ Stabbing ___ Throbbing ___ Cramping ___ Burning

___ Limited Range of Motion ___ Limited Use

Please circle on the diagram any area of pain or injury:



Area/Description of Symptoms	Pain Level 0-10 (10 as highest)	Frequency

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Diet, Exercise, Lifestyle:

Dietary preference/restrictions? __________________________ Cravings? _________________________

What is your favorite food? ______________________________ Favorite Flavor? ___________________

Do you eat meals regularly? ___ Yes ___No

Physical Exercise: ___ Avoid ___ Regular ___ Sporadic ___ Rare ___ Not Now

Type of exercise? ____

Tobacco? _______ How Much? _______ Previously _______ How much? ________ How Long?

Caffeine? _______ How Much? _______ How Often?

Alcohol? _______ How Much? _______ How Often?

Marijuana? _______ How Much? _______ How Often?

Other mood/mind altering substances (past/present)? ____

How do you feel about the following areas of your life?

	Great	**Good**	**Fair**	**Poor**	**Comments**
Self					
Work					
Spouse/Partner					
Sex					
Family					
Diet					
Spiritual Life					

Recent significant life events? (i.e. divorce, relocation, job change, death in family, etc,) ______________

____

____

____

I commonly cope with stressful periods by: ____

____

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FOR WOMEN ONLY

MENTRUAL PERIODS

Please complete this section to the best of your ability, even if you no longer menstruate. It provides valuable information for an accurate assessment.

Since the age of ____, I've had a regular ☐ Yes ☐ No flow that lasts ____ days. My full length of cycle is ____ days.

Color of blood: ☐ Light red ☐ Dark red ☐ Brownish ☐ Other ______________________

☐ Light ☐ Heavy ☐ Clots

Date of last menses: ________________ ☐ PMS ☐ Breast tenderness

☐ Moodiness ☐ Bloating ☐ Other ___________ Cramps? Which days? ____________

HISTORY

Mark the following: **1** – If current **2** – If past

	Hysterectomy		Pain w/Intercourse		Fibroids		Breast Reconstruction
	D & C		Dryness w/Intercourse		Lumpectomy		Irregular Bleeding
	Tubular Ligation		Interstitial Cystitis		Mastectomy		Breast Implants
	Yeast Infection		Breast Lumps		Ablation		

	Vaginal Discharge	Color:	Frequency:	Amount:

Date of last PAP smear: _______________________________ Results? ______________________________

PREGANCY/BIRTH CONTROL

Are you pregnant now? ☐ Yes ☐ No Do you think you may be pregnant? ☐ Yes ☐ No

Number of pregnancies: ___________ Number of children: ______________

Terminations: _____________ Miscarriages: _____________ Tubular pregnancies: _______________

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FOR WOMEN ONLY

Difficulty conceiving? ____

____

____

Birth control? ___________________

MENOPAUSE

No menses since: ____

Experiences/symptoms you are currently feeling/having: ___________________________________

____

____

____