Acupuncture Patient Information Form

Way of Wellness
Natural Healthcare, Inc.
940 Saratoga Ave. Ste 104
San Jose, CA 95129

Practitioner last name	First name	M.I.	License #	Phone #	Fax #
	Shasta		AC5149	408-615-1995	408-615-1999

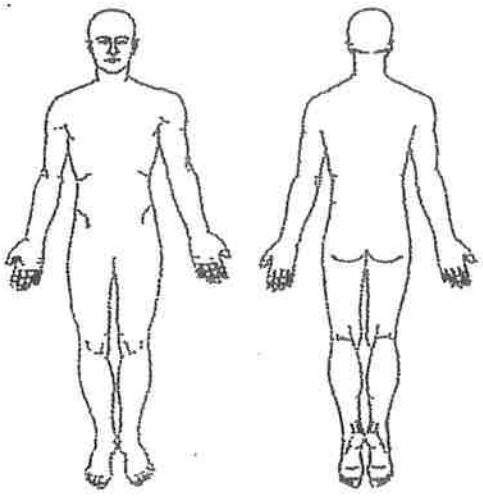
Patient to complete the following sections: Email Address: _____

Patient last name	Patient First Name	M.I.	Gender ☐M ☐F	Age	Date of Birth (MM/DD/YYYY) / /
Insured ID or SSN	Insured Last Name	M.I.	First Name		Patient Daytime Phone
Patient Address		City		State	Zip
Employer Name	Insurance Company		Group Plan # or Union Local		
Is illness or injury related to: ☐Work ☐Auto ☐Other	Do you have other insurance that might cover this illness/injury? ☐Yes ☐No		If yes, please list other insurance company name:		

Please list your reason(s) for this visit or your condition(s) in order of importance:	Date you first noticed:	Using a scale in which "0" is none (no pain or symptoms) and "10" is severe pain or symptom(s), circle the number that best reflects your condition: ↓ none ..... to ..... severe ↓	Please check the box below that best represents how much of the time you feel pa or your symptom(s) for the listed reason:
1. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-10(
2. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-10(
3. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-10(
4. _____	_____	0 1 2 3 4 5 6 7 8 9 10	☐0-25% ☐26-50% ☐51-75% ☐76-10(

Please mark the areas of discomfort or pain on the figures to the right using the symbol that best describes the feeling:

+++ Sharp or stabbing
ooo Pins and needles
vvv Dull or aching
/// Numbness



Please check the box that best describes whether your pain or symptom(s) limit norm activities:

Activity	normal	somewhat limited	severe limited
Lifting	☐	☐	☐
Bending	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Sitting	☐	☐	☐
Climbing stairs	☐	☐	☐
Running	☐	☐	☐
Resting in bed	☐	☐	☐
Intercourse	☐	☐	☐
Computer work/typing	☐	☐	☐
Normal work	☐	☐	☐
Household activities	☐	☐	☐
Recreational activities	☐	☐	☐
Other (list below)	☐	☐	☐

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Women's Fertility History

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE) | DATE

Age at which menses began _____

Are your periods painful? ☐ Yes ☐ No

How many days does the pain last?_____

How many days do you normally bleed?_____

How heavy is the bleeding? ☐ Light ☐ Normal ☐ Heavy

What color is the blood? ☐ Light red ☐ Red ☐ Dark red ☐ Purple ☐ Brown ☐ Black

Is there clotting? ☐ Yes ☐ No

Do you have premenstrual tension? ☐ Yes ☐ No

Does your face break out before or during your period? ☐ Yes ☐ No

Do your breasts become tender premenstrually? ☐ Yes ☐ No

Do you bleed or spot between periods? ☐ Yes ☐ No

Are your menstrual cycles spaced irregularly? ☐ Yes ☐ No

How many days are there from from one period to the next?_____

Date of last menstrual period_____

	Number	Years
How many pregnancies have you had?	____	_____
How many children do you have?	____	_____
How many abortions have you had?	____	_____
How many miscarriages have you had?	____	_____
How many times has a D&C been performed?	____	_____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Have you ever had a cervical biopsy, operation, cauterization or conization? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

Do you get yeast infections regularly? ☐ Yes ☐ No

Have you ever been diagnosed with a chlamydial infection? ☐ Yes ☐ No

Do you have chronic vaginal discharge? ☐ Yes ☐ No

Do you have any sores on your genitalia? ☐ Yes ☐ No

Have you ever had pelvic inflammatory disease? ☐ Yes ☐ No
Were you treated for it? ☐ Yes ☐ No

How_____

_____

Date of last Pap smear_____

Have you ever been diagnosed with uterine fibroids or polyps? ☐ Yes ☐ No

Have you ever been diagnosed with endometriosis? ☐ Yes ☐ No

Have you been diagnosed with pelvic adhesions? ☐ Yes ☐ No

Have you been diagnosed with any pelvic abnormalities? ☐ Yes ☐ No

Have you taken any medications for gynecological conditions other than contraceptives?

Medication	Reason	How long
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have your cycles changed since they began? ☐ Yes ☐ No

How? _____

Do you ovulate on your own? ☐ Yes ☐ No

On what day of your cycle?_____

Do your breasts get tender at/during ovulation? ☐ Yes ☐ No

Do you get premenstral low back pain? Yes No

Do your bowel movements become loose at the beginning of you period? ☐ Yes ☐ No

Women's Fertility History *Continued*

Have you had fertility treatments? ☐ Yes ☐ No

If yes, when and where?_____

By whom?_____

What types?_____

Have you taken medication to help you ovulate? ☐ Yes ☐ No

When _____ How long?_____

Have your fallopian tubes been evaluated medically? ☐ Yes ☐ No

What were the results?_____

Have you had any tubal operations? ☐ Yes ☐ No

Have you had any hormone laboratory tests performed? ☐ Yes ☐ No

What were the results?_____

_____

Do you have a single partner with whom you have been trying to conceive? ☐ Yes ☐ No

How long have you been married or living together?_____

Has he had a fertility workup? ☐ Yes ☐ No

What were the results?_____

Is your partner supportive of your wish to conceive? ☐ Yes ☐ No

Have you taken oral contraceptives? ☐ Yes ☐ No

When _____ How long?_____

Have you ever had an IUD? ☐ Yes ☐ No

When _____ How long?_____

Have you ever taken DepoProvera? ☐ Yes ☐ No

When _____ How long?_____

How long have you been trying to conceive? _____

Have you had a diagnosis relating to infertility? ☐ Yes ☐ No

What was it?_____

COMMENTS/NOTES

How is your sexual energy? ☐ Low ☐ Normal ☐ High

Do you douche regularly? ☐ Yes ☐ No

With what?_____

Do you use vaginal lubricants? ☐ Yes ☐ No

Are you more than 20% over your ideal body weight? ☐ Yes ☐ No

Are you more than 20% below your ideal body weight? ☐ Yes ☐ No

Do you have a stressful occupation? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Do you have excessive facial hair? ☐ Yes ☐ No

Do you have excessively oily skin? ☐ Yes ☐ No

Have you experienced excessive loss of head hair? ☐ Yes ☐ No

Have you noticed discharge from your nipples? ☐ Yes ☐ No

Was your mother exposed to diethylstilbestrol (DES) when she was pregnant with you? ☐ Yes ☐ No

Have you been exposed to any known environmental toxins or hormones? ☐ Yes ☐ No

Are you presently taking steroids? ☐ Yes ☐ No

Questions / Section	Yes	No
Diagnosis		
DIAGNOSIS		
KIDNEY YIN DEFICIENCY		
Do you have lower back weakness. Soreness. Or pain, knee problems?	Yes	No
Do you have ringing in your ears or dizziness?	Yes	No
Is your hair prematurely gray?	Yes	No
Do you vaginal dryness?	Yes	No
Is your midcycle fertile cervical mucus scanty or missing?	Yes	No
Do you have dark circles around or under your eyes?	Yes	No
Do you have night sweats?	Yes	No
Are you prone to hot flashes?	Yes	No
Would you desctibe yourself as afraid a lot?	Yes	No
Does your tongue lack coating? Does it appear shiny or peeled?	Yes	No
DIAGNOSIS		
KIDNEY YANG DEFICIENCY		
Do you have lower back pain premenstrually?	Yes	No
Is your low back sore or weak?	Yes	No
Are you feet cold, especially at night?	Yes	No
Are you typically colder than those around you?	Yes	No
Is your libido low?	Yes	No
Are you often fearful?	Yes	No
Do you wake up at night or early in the morning because you have to urinate?	Yes	No
Do you urinate frequently, and is the urine diluted and/or profuse?	Yes	No
Do you have early morning loose, urgent stolls?	Yes	No
Do you have profuse vaginal discharge?	Yes	No
Does your menstrual blood tend to be dull in color?	Yes	No
Do you feel cold cramps during your period that respond to a heating pad?	Yes	No
Is your tongue pale, moist, and swollen?	Yes	No
Is your temperature lower than 97.8	Yes	No
Do you have hypothyroidism?	Yes	No
DIAGNOSIS		
SPLEEN QI DEFICIENCY		
Are you often fatigued?	Yes	No
Do you have poor appetite?	Yes	No
Do you feel bloated after a meal?	Yes	No
Do you crave sweets?	Yes	No
Do you have loose stools, abdominal, or digestive problems?	Yes	No

Are your hands and feet cold?	Yes	No
Is your nose cold?	Yes	No
Are you prone to feeling heavy or sluggish?	Yes	No
Do you bruise easily?	Yes	No
Do you think you have poor circulation?	Yes	No
Do you have varicose veins?	Yes	No
Are you lacking strength in your arms and legs?	Yes	No
Are lacking exercise?	Yes	No
Are you prone to worry?	Yes	No
Have you been diagnosed with low blood pressure?	Yes	No
Do you sweat a lot without exerting yourself?	Yes	No
Do you feel dizzy or light-heade, or have visual changes when you stand up fast?	Yes	No
Is your menstruation thin, watery, profuse, or pinkish in color?	Yes	No
Are you more tired around ovulation or menstruation?	Yes	No
Do you ever spot a few days or more before your period comes?	Yes	No
Have you ever been diagnosed with uterine prolapse?	Yes	No
Are your menstrual cramps accompanied by a bearing down sensatiom in your uterus?	Yes	No
Are you often sick, or do you have allergies?	Yes	No
Have you been diagnosed with hypothyroid or anemia?	Yes	No
Do you have hemmorrhoids or polyps?	Yes	No
Does your tongue look swollen, with teeth marks on the sides?	Yes	No
Do you have a pale, yellowish complexion?	Yes	No
Is the menstrual blood thick and dar, or purplish in color?	Yes	No
Is your tongue dark and purplish in color?	Yes	No

DIAGNOSIS
BLOOD DEFICIENCY

Are your menses scanty or late?	Yes	No
Do you have dry, flaky skin?	Yes	No
Are you prone to getting chapped lips?	Yes	No
Are your fingernails or toenails brittle?	Yes	No
Are you losing hear on your head(not in patches, but all over)?	Yes	No
Do you have diminishe nighttime vision?	Yes	No
Do you get dizzy or light-headed around your period?	Yes	No
Are your lips, the inner side of your lower eyelids, or tongue pale in color?	Yes	No

DIAGNOSIS
BLOOD STASIS

Is your menstrual flow ever brown or black in color?	Yes	No
Do you feel midcycle pain around your ovaries?	Yes	No
Do you have painful, unmovable breast lumps?	Yes	No
Do you experience periodic numbness of your hands and feet? (especially at night)	Yes	No

Do you have varicose or spider veins?	Yes	No
Do you have red hemangiomans (cherry-red spots) on your skin?	Yes	No
Does your compexion appear dark and 'sooty'?	Yes	No
Does you have chronic hemorrhoids?	Yes	No
Does your menstrual blood contain clots?	Yes	No
Have you been diagnosed with endometriosis or uterine fibroids?	Yes	No
Is your lower abdomen tender to palpatation (resisting touch)?	Yes	No
Can you feel any abnormal lumps in your lower abdomen?	Yes	No
Do you have piercing or stabbing menstrual cramps?	Yes	No
Does your tongue look dark?	Yes	No
Do you gave dark spots on your tongue?	Yes	No
Are the veins beneath your tongue twisty and tortuous?	Yes	No
Do you uterinate frequently, and is the urine diluted and/ or profuse?	Yes	No
Do you have early morning loose, urgent stools?	Yes	No
Do you have profuse vaginal discharge?	Yes	No
Does your menstrual blood tend to be dull in color?	Yes	No
Do you feel cold cramps during your period that respond to a heating pad?		

DIAGNOSIS

LIVER QI STAGNATION (Liver Qi Deficiency)

Are you prone to emotional depression?	Yes	No
Are you prone to anger and/or rage?	Yes	No
Do you become irritable premenstrually?	Yes	No
Do you feel bloated or irritable around ovulation?	Yes	No
Does it feel as if your ovulation lasts longer than it should?	Yes	No
Are your breasts sensitive/sore at ovulation?	Yes	No
Do you experience nipple pain or discharge from your nipples?	Yes	No
Do you have a lot of premenstrual breast distention or pain?	Yes	No
Have you been diagnosed with elevated prolactin levels?	Yes	No
Do you become bloated premenstrually?	Yes	No
Are your pupils usually dilated and large?	Yes	No
Do you have difficulty falling asleep at night?	Yes	No
Do you experience heartburn or wake up with a bitter taste in your mouth?	Yes	No
Are your menses painful?	Yes	No
Do you feel your menstrual cramps in the external genital area?	Yes	No
Is the menstrual blood thick and dark, or purplish in color?	Yes	No
Is your tongue dark or purlish in color?	Yes	No

DIAGNOSIS

HEART DEFICIENCY (often associated with heat)

Do you wake up early in the morning and have trouble getting back to sleep?	Yes	No
Do you have heart palpitations, especially when anxious?	Yes	No

Do you have nightmares?	Yes	No
Do you seem low in spirit or lacking in vitality?	Yes	No
Are you prone to agitation or extreme restlessness?	Yes	No
Do you fidget?	Yes	No
Is the tip of your ongue red?	Yes	No
Is there a crack in the center of your tongue that extends to the tip?	Yes	No
Do you sweat excessively, especially on your chest?	Yes	No

DIAGNOSIS
EXCESS HEAT

Is your pulse rate rapid?	Yes	No
Are your mouth and throat usually dry?	Yes	No
Are you thirsty for cold drinks most of the time?	Yes	No
Do you often feel warmer than those around you?	Yes	No
Do you wake up sweating or have hot flashes?	Yes	No
Do you break out with red acne (especially premenstrually)?	Yes	No
Do you have a short menstrual cycle?	Yes	No
Do you have vaginal irritation or rashes?	Yes	No

DIAGNOSIS
DAMPNESS

Do you feel tired and sluggish after a meal?	Yes	No
Do you have fibrocystic breasts?	Yes	No
Do you have cystic or pustular acne?	Yes	No
Do you have urgent, bright, or foul-smelling stools?	Yes	No
Does your menstrual blood contain stringy tissue or mucus?	Yes	No
Are you prone to yeast infections and vaginal itching?	Yes	No
Do your joints ache, especially with movement?	Yes	No
Are you overweight?	Yes	No
Do you have a wet, slimy tongue?	Yes	No

\
DIAGNOSIS
DAMP HEAT

Do you have signs of heat and/or dampness as indicated above?	Yes	No
Do you have foul-smelling, yellow, or greenish vaginal discharge?	Yes	No
Are you prone to vaginal and/or rectal itching during your luteal or premenstrual phas	Yes	No

DIAGNOSIS
COLD UTERUS

Do you fit the Kidney Yang deficiency category?	Yes	No
Do you fall into the Blood stasis pattern?	Yes	No
\Does your lower abdomen feel cooler to the touch than the rest of your trunk?	Yes	No

Patient's Name _____

Month(s) _____ Year _____ Last 12 Cycles: Shortest _____ Longest _____ This Cycle's Length _____

Cycle Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
Date																																													
Day of Week																																													
Intercourse																																													
Time Temp Taken																																													
Waking Temperature	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99	99
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	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
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	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97
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Cycle Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45
Cervical Fluid																																												
Vaginal Sensation																																												
Cervix																																												
Cervical Fluid Description																																												
Hormone Levels																																												
Follicle Sizes																																												
OPK/LH Surge																																												
Ovulatory Pain																																												
Fertility Medication																																												
Miscellaneous																																												
Cramps																																												
Bloated																																												
Headaches																																												
Sore Breasts																																												
Emotional																																												

TCM DIAGNOSIS: Traditional Chinese Medicine

FERTILITY LAB WORK TO CHECK:

WOMEN: FSH, E2, LH, Progesterone, HCG, Prolactin, GnRH, Basal body temperature chart, Thyroid: TSH, free T3, free T4, antithyroblobulin, antiTPO, and autoimmune tests.

MEN: Sperm: count, motility, morphology, sperm DNA fragmentation, and viscosity.

OTHER: In depth autoimmune tests (see Reproductive Endocrinologist), i.e. antinuclear antibody (ANA), anticardiolipin antibody (ACA), antiphosphlipid antibody (APA), or lupus anticoagulant.

WESTERN DIAGNOSIS (circle what applies to you)

1. **LUTEAL PHASE DEFECT** - need to strengthen the kidneys and spleen in TCM
2. **OVARIAN AGE** - if over 35. Deficient Kidney Jing – TCM
3. **"UNEXPECTED INFERTILITY"** – usually due to liver qi stagnation (70%) and deficient kidney qi (30%) in TCM. Kidney Yin & Yang Def., Liver Qi Stagnation, or Blood Deficiency according to TCM.
4. **IMMUNOLOGIC REACTION AND RECURRENT MISCARRIAGE** – spleen, liver, and kidney deficiencies in TCM and/or damp: in blood flow (stagnation or overabundance); in the levels of Yin or Yang; or in the level of Qi energy.
5. **ENDOMETRIOSIS AND FIBROIDS** – general kidney deficiency in conjunction with Blood stagnation in TCM.
6. **POLYCYSTIC OVARIAN SYNDROME** – dampness and phlegm due to excess or deficiencies in body; yang def. with excess phlegm – in TCM.
7. **MECHANICAL INFERTILITY**
   A) Pelvic Inflammatory Disease (PID) usually from chlamydia can cause fallopian tube obstruction (damp cold or damp heat in TCM)
   B) Fallopian Tube Obstruction can result in ectopic pregnancies. Need a laparoscopy or some type of surgery (stagnant blood in TCM)
   C) Pelvic Adhesions – adhesions and/or scar tissue inside or outside the organs of the reproductive tract. Can be due to trauma or endometriosis, yeast or bladder infection, PID or surgeries (D&C, abortion, cesarean section or appendectomy). Due to blood stagnation in TCM.
8. **GENETIC ABNORMALITIES** – two uteruses, etc.
9. **HYPOTHYROIDISM** – deficient kidney, spleen, and heart yang in TCM
10. **MALE FACTOR** – deficient sperm count (less than 20 million per milliliter), insufficient sperm motility (over 50% should be motile), poor sperm morphology (less than 30% normal form), anti-sperm antibodies, mechanical obstruction. TCM causes: 1) Deficiency of the kidney ying or yang, or spleen Qi deficiency, or 2) excess of stagnation or damp heat in the pelvic organs.
11. **OTHER HORMONAL ABNORM ALITIES**

Reference: The Infertility Cure by Randine Lewis, Ph.D.

Way of Wellness
Natural Healthcare, Inc.
940 Saratoga Ave. Ste 104
San Jose, CA 95129

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Ph: (408) 615-1995
Fax: (408) 615-1999

CONSENT TO TREATMENT

I, the undersigned, understand that methods of treatment used in this practice may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, herbal therapy, massage, Qi Gong, and nutritional counseling.

I understand that acupuncture, moxibustion, electrical stimulation, cupping and pricking are all safe methods of treatment. Potential risks include temporary bruising, swelling, bleeding, numbness and tingling, and soreness at the needling site that may last a few days. Unusual risks of acupuncture include dizziness, fainting or nerve damage. Infection is possible, although the clinic uses alcohol and sterile disposable needles and maintains a safe and clean environment. Potential risks of moxibustion health therapy are burns, blistering, or scarring. Temporary bruising or redness lasting a few days is a common side effect of cupping and gua sha, or spooning. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments.

I will notify the acupuncturist should I become pregnant or if I am in the process of trying to get pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

I understand that herbal and nutritional supplements recommended to me by my acupuncturist are safe in the recommended doses. Large doses of herbs taken without my practitioner's recommendation may be toxic, and some herbs are inappropriate during pregnancy. Some possible side effects of herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue. I understand that I must stop taking any herbs and notify my acupuncturist as soon as I experience any discomfort or adverse reactions.

I understand that my acupuncturist may review my medical records and lab reports, but all my records will be kept confidential. If it becomes necessary to share my health information, this will be handled in accordance with the stipulations detailed in the Notice of Privacy Practices document that has been provided to me, and of which I have acknowledged receipt.

I understand that I can discuss risks and benefits further with my practitioner before signing if I so choose. However, I do not expect my practitioner to be able to anticipate and explain all possible risks and complications of treatment. I rely on the practitioner to exercise his or her judgment in my best interest during the course of treatment, based upon the facts then known.

In signing this form, I acknowledge any inherent risks, and give my consent for treatment, payment and healthcare operations received, incurred or carried out at this practice.

Patient Signature _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This notice summarizes how health data about you may be used and shared and how you can get access to this data. IMPORTANT NOTE: This does not include all of the details about our privacy policy. For more details, please read the NOTICE OF PRIVACY PRACTICES that your practitioner has provided you.

I. How we may use and share health data about you:

a) Treatment - To give you medical treatment or other types of health services.
b) Payment - To bill you or a third party for payment for services provided to you.
c) Health Care Operations - For our own operations such as quality control, compliance monitoring, audit, etc.

II. Disclosures where we do not have to give you a chance to agree or object:

a) To you
b) As required by federal, state, or local law
c) If child abuse or neglect is suspected
d) Public health risks (for public health activities to prevent and control spread of disease)
e) Lawsuits and disputes (in response to a court or administrative order)
f) Law enforcement (to help law enforcement officials respond to criminal activities)
g) Coroners, medical examiners and funeral directors
h) Organ or tissue donation facilities if you are an organ donor
i) To avert a threat to an individual or to public health safety

III. Disclosures where we have to give you a chance to agree or object:

a) Patient directories - You can decide what health data, if any, you want to be listed in patient directories.
b) Persons involved in your care or payment for your care - We may share your health data with a family member, a close friend, or other person that you have named as being involved with your health care.

IV. Other uses of health data: Other uses not covered by this notice or the laws that apply to us will be made only with your written consent.

V. You have the following rights relating to the health data we keep about you:

a) Right to inspect your health record and to receive a copy of your health record upon request
b) Right to amend information in your health record you believe is inaccurate or incomplete
c) Right to know to whom we have disclosed your health information
d) Right to ask for limits on the health information data we give out about you
e) Right to receive communication from us about your health information in alternate ways
f) Right to a paper copy of the complete Notice of Privacy Practices

I acknowledge that I have received the NOTICE OF PRIVACY PRACTICES of this practice.

_____

Signature of or representative Date

_____

Print patient name Patient Birth Date -11/12/08sc

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FINANCIAL POLICY

Welcome you to our family of acupuncture providers and we are committed to your treatment being successful. Please understand that payment of your bills is part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

Payment is expected as services are rendered. If you are covered by insurance, we expect payment for deductibles and co-payments on the date of services. We accept cash, or check.

Regarding Insurance

We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have completed insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 45 days of billing, the balance become your responsibility. Your insurance policy is a contract between you and insurance company and we are not a party to that contract. You will be expected to contact them directly if a problem should arise. We expect all balances to be cleared in less than 45 days.

Usual and Customary Rates

Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only estimate what your insurance will pay since each insurance company has their specific limitations and exclusions.

Billing

For all accounts over 45 days with patient amounts due, there will be a $10.00 billing fee or a finance charge of 1.5% per month, whichever is more. We assign all accounts over 120 days to a collection service for processing.

There will be a charge of $ 25.00 for any cancelling an appointment without a 24 hour notice or for failing an appointment.

You agree to pay any reasonable additional fees, including any all collection agency, legal fees and /or court cost, necessary to collect this amount.

I agree to this financial policy, and I have read and received a copy of this statement.

Patient or Parent/Guardian Signature_____ Date_____