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

INITIAL HEALTH STATUS

Patient Name ____________________ (Last) ____________________ (First) Birthdate __________ Sex M / F

Address ____________________ City ____________________ State ______ Zip __________

Subscriber Name: ____________________ Subscriber ID #: __________ Group #: __________

Phone # (Home): __________ Work #: __________ Employer __________ Occupation __________

Social Security #: __________ Primary Health Plan: __________ Patient/Member ID #: __________

2nd Health Plan: __________ Primary Care Physician: __________ (Required) PCP phone #: __________ (Required)

Please describe your current health problem(s): ____________________

How and When it began: ____________________

If you are undergoing acupuncture treatments, describe your progress: ____________________

☐ Worsened ☐ No change ☐ 25% improved ☐ 50% improved ☐ 75% improved

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other: __________

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

How often are your symptoms present? ☐ Constantly ☐ Frequently ☐ Intermittently ☐ Occasionally

Describe your current health condition: ☐ Good ☐ Fair ☐ Poor ☐ Chronically ill

Can you perform your daily activities? ☐ Yes, all activities ☐ Some activities ☐ Not at all

Are you currently under the care of a physician? ☐ No ☐ Yes, please explain __________

What treatment have you been taking for the above condition(s)? (Surgery, medications, injections, therapy, chiropractic, etc.) ____________________

Past	Present		Past	Present		Past	Present	
☐	☐	Alcohol/tobacco/drug dependence	☐	☐	Frequent urination	☐	☐	Sinusitis
☐	☐	Abnormal menstruation	☐	☐	Headache	☐	☐	Stroke
☐	☐	Allergies	☐	☐	Heart attack	☐	☐	Thyroid Disease
☐	☐	Angina	☐	☐	Heartburn or indigestion	☐	☐	Medications __________
☐	☐	Arthritis/ rheumatoid arthritis	☐	☐	High blood pressure	☐	☐	Other: __________
☐	☐	Artificial joints	☐	☐	Hospitalizations/surgical procedures __________			
☐	☐	Asthma	☐	☐	Kidney disease			
☐	☐	Blood disorder	☐	☐	Liver problems			
☐	☐	Breast lumps	☐	☐	Pacemaker			
☐	☐	Cancer/tumor	☐	☐	Painful menstruation			
☐	☐	Convulsions/seizures	☐	☐	Palpitation/arrhythmia			
☐	☐	Diabetes	☐	☐	Peptic ulcer			
☐	☐	Diarrhea/constipation	☐	☐	PMS			
☐	☐	Excessive thirst	☐	☐	Pregnancy, months _____			
☐	☐	Fainting or dizziness	☐	☐	Prostate problems			
☐	☐	Fatigue	☐	☐	Rapid weight gain/loss			

If a family member has had any of the following, please mark the appropriate box and explain:

☐ Arthritis ☐ Lupus
☐ Cancer ☐ Mental disorders
☐ Heart disease
☐ Hypertension
☐ Other: __________

Comments: ____________________

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my Doctor of Acupuncture Provider and Clinical Services Manager may need to contact my PCP if my condition needs to be co-managed. Therefore, I give my authorization to Dr.Ericson contact my medical doctor if necessary.

Patient signature: ____________________ Date: __________

EMAIL: ____________________

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Report of Findings

Personal Report of Findings for ______________________ **Date** __________

Your health concerns
1) ______________________ 3) ______________________
2) ______________________ 4) ______________________

What we found →

Patient: check any of the boxes below that apply to you in the last 6 months

Lung & Large Intestine Meridian/Organ Network

- ☐ Allergies
- ☐ Arm/wrist/elbow pain
- ☐ Asthma/bronchitis
- ☐ Constipation
- ☐ Cough/sneeze/phlegm
- ☐ Eczema/psoriasis/rash
- ☐ Flatulence
- ☐ Frequent colds
- ☐ Frontal/sinus HA
- ☐ Grief/sadness
- ☐ Lethargy/fatigue
- ☐ Loose stools
- ☐ Mucus
- ☐ Nasal problems
- ☐ Shoulder pain
- ☐ Sinusitis
- ☐ Smell problems
- ☐ Stiff joints/neck
- ☐ Sweating prob.
- ☐ Weak voice
- ☐ Wheezing/SOB

Other ____________

Kidney & Bladder Meridian/Organ Network

- ☐ Adrenal weakness
- ☐ Back/hip/knee pain
- ☐ Bladder infec./control
- ☐ Brittle bones
- ☐ Cold hands/feet
- ☐ Dark/Puffy around eyes
- ☐ Depression/fear
- ☐ Edema/water retention
- ☐ Hot flashes
- ☐ Impotence/libido
- ☐ Infertility/sterility
- ☐ Lethargy/fatigue
- ☐ Loss/thinning hair
- ☐ Night sweats
- ☐ Poor memory
- ☐ Premature gray
- ☐ Sciatica/back pain
- ☐ Sore throat in AM
- ☐ Tight hamstrings
- ☐ Tinnitus
- ☐ Urine problems

Other ____________

Liver & Gallbladder Meridian/Organ Network

- ☐ Anger/irritability
- ☐ Breast tenderness
- ☐ Brittle/coarse nails/hair
- ☐ Bruising
- ☐ Depression
- ☐ Distention/bloating
- ☐ Eye/vision problems
- ☐ Flatulence
- ☐ Headaches
- ☐ Hemorrhoids
- ☐ Indigestation
- ☐ Irritable bowel
- ☐ IT Band tightness
- ☐ Lack of flexibility
- ☐ Menstraul irreg.
- ☐ Migraines
- ☐ Nausea/vomiting
- ☐ PMS
- ☐ Stick neck/shoulder
- ☐ Tension/cramps
- ☐ Tinnitus

Others____________

Heart & Small Intestine Meridian/Organ Network

- ☐ Abdominal pain
- ☐ Anemia
- ☐ Anxiety/dread
- ☐ Digestive troubles
- ☐ Dream dist sleep
- ☐ Elbow/shoulder pain
- ☐ Hearing problems
- ☐ Heart problems
- ☐ Hot flashes
- ☐ Hot/painful joints
- ☐ Lack of joy/humor
- ☐ Mouth/tongue sores
- ☐ Neck pain
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Restlessness
- ☐ Sleeping problems
- ☐ Tongue/speech
- ☐ Upper back pain
- ☐ Urine problems
- ☐ Wrist pain

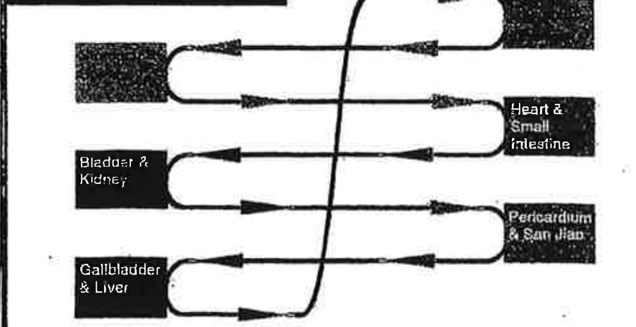
Other ____________

Spleen & Stomach Meridian/Organ Network

- ☐ Abdominal pain
- ☐ Aching/heavy limbs
- ☐ Anemia
- ☐ Appetite/digestive prob
- ☐ Belching
- ☐ Bruise indigestion
- ☐ Colic/indigestion
- ☐ Difficulry focused
- ☐ Distention/bloating
- ☐ Headaches
- ☐ Heaviness at heard
- ☐ Hemorrhoids
- ☐ Hiccups
- ☐ Irritable bowel
- ☐ Lethargy/fatigue
- ☐ Loose stools
- ☐ Muscle Weakness
- ☐ Nausea/vomiting
- ☐ Poor memory
- ☐ Prolapse
- ☐ Worry/overthing

Other ____________

Qi Flow within the Body



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Informed Consent to Receive Treatment and Care

You are always welcome to ask for more details if you wish. Contraindications(symptoms or conditions that make a particular treatment inadvisable) for acupuncture treatment and certain herbs include a history of bleeding disorder or current anticoagulation therapy, and implanted pacemaker or prosthetic heart valve, use of certain medications, and/or pregnancy. It is important that you notify your practitioner if any of these apply to you.

_____ I understand that the diagnosis given to me conforms to the principles of Traditional Chinese Medicine (TCM), and in no way purports to replace allopathic medical evaluation, diagnosis, or treatment.

I have provided a full history and description of the complaints and health status which is complete and accurate. I understand the need for communication with all of my health care providers regarding my health status is ongoing and necessary.

_____ I understand that no guarantee has been made concerning the use and effects of Traditional Chinese Medicine (TCM). I understand that in some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is sustained.

_____ I understand that I may stop treatment at any time.

_____ I understand that while this document describes major risks of treatment, other side effects and risks may occur.

_____ Acupuncture: I understand that it is a technique using small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. The location and the application of the needles and the depth of the needle insertion is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of the skin, hematoma, a bruise at the site of needling, or fainting. Momentary euphoria or light headedness may occur after treatment. Some very rare risks of acupuncture include spontaneous abortion, pneumothorax (air in the chest cavity that could cause a collapsed lung) and infection.

_____ Moxibustion: I understand that this is the application of indirect heat supplied by burning the herb Folium Artemesiae Vulgaris over a single acupuncture point or group of points. This generally produces a sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidences, a minor burn may occur at the site of moxibustion.

_____ Cupping: I understand that this is the application of round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions, a minor blister which may persist for up to a week. These marks may resolve on their own and are not indications of complications or injury.

_____ Acupressure/Tui Na Massage: I understand that I may be given acupressure massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiologic functions. I am

aware that side effects may result from this treatment 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.

_____ **Herbs and Nutritional Supplements:** I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction, to modify or prevent pain perception, and to normalize the body's physiologic functions. Herbs are used to facilitate the body's own restorative process. The herbs are usually taken in tea form or mixing powdered granules. I understand that I am not required to take these substances but must follow the direction for administration and dosage if I do decide to take them.

_____ I understand that recommended herbs are traditionally considered safe in the practice of TCM, although some may be toxic in large doses. I understand that some dietary supplements are inappropriate during pregnancy, may interact with medications or other supplements, may have side effects of their own, or may contain potentially harmful ingredients not listed on the label. I also understand that most supplements have not been tested in pregnant women, nursing mothers, or children. Potential risks include but are not limted to: allergic reactions, nausea, gas, stomachache, vomiting, headache, diarrhea, rash, hives, and tingling of the tongue. Some possible side effects of applying topical creams, liniments, ointments and plasters are rashes, hives and tingling of the skin. I will immediately notify my practitioner if any unanticipated or unpleasant effects associated with herb or supplement treatment.

_____ I understand that it is not possible to anticipate and explain all risks and complications. I understand and agree that my practitioner will exercise judgment during the course of treatment which they feel at the time, based on the facts known to them, is in the best interest of me as a patient.

_____ I hereby state that I have read and understand this form, that I have been given an opportunity to ask questions, and that all questions have been answered in a satisfactory manner. I wish to proceed with TCM treatment. I understand that I am free to withdraw my consent to treatment at any time.

____

Patient Name:

____

Signature of Patient or person authorized to consent on behalf of the patient:

____

Date:

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

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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NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG' is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advise is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above:

Signature Date:

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Financial Policy

Welcome to our family of acupuncture providers, we are committed to your treatment being successful. Please understand that payment of your bills is a 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 service. We accept cash, check, or credit cards.

Regarding insurance: We verify your insurance as a courtesy to you. HOWEVER, ***you are ultimately responsible for your payment of any co pays/coinsurance***. Insurance carriers can and do make mistakes when verifying coverage as such you may want to confirm your benefits and read your explanation of benefits as you receive them in the mail. In order to provide this service to you, we must have completed insurance information and confirmation of your coverage. 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 within 45 days of billing, the balance if a problem occurs. 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. We assign all accounts over 120 days to a collection service for processing. You agree to pay any reasonable additional fees, including all collection agency, legal fees and/or court cost, necessary.

Cancellation policy: **There will be a charge of $25.00 for any cancelling an appointment without a 24 hour notice or for failing an appointment.** Online deals have their own cancellation policies. Groupon requires a "24 hour cancellation notice." Amazon's policy says "24 hour notice or subject to forfeiture." Our policy for these online deals is 24 hour notice or that session is forfeited. The amount paid for the voucher never expires and can be applied to future visits at the regular fee for services (see these terms on the online terms and conditions).

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

Patient or parent/guardian signature________________________________ ***DATE:***__________