Rona's Acupuncture Clinic

Office Procedures & Patient Introduction

(*Please read carefully before completing)*

This clinic specializes in acupuncture care. We ask you to fill out this form for either consultation, or examination purposes. Examinations are done routinely to determine the nature and extent of your concern. The acupuncturist will explain the level of examination necessary for your type of condition.

Date_____

Full Name_____

SSN_____ Birth Date_____/_____/_____

Marital Status_____ # of Children_____

Address _____

City_____State_____Zip _____

Phone (_____)_____ Cell (_____)_____

Email_____

Occupation_____

Referred by_____

Person responsible for account _____

Complaints or existing condition_____

Complaints secondary to these _____

Any known allergies _____

Current or Previous Dr. Name and Phone # _____

Doctor's Diagnosis_____

_____

Please check all of the below conditions that apply: (*This is not a detailed history)*

- ❑ Tendency to faint
- ❑ Tendency to bleed for a long time
- ❑ Have AIDS
- ❑ Have Hepatitis
- ❑ Heart Problems
- ❑ Been treated by acupuncture before
- ❑ Prior surgeries
- ❑ Have high blood pressure
- ❑ Tendency to bruise or discolor
- ❑ Have high blood pressure
- ❑ Respiratory problems
- ❑ Other therapies being undertaken at this time
- ❑ Taking medications
- ❑ Exhausted at the present time
- ❑ Hungry at the present time
- ❑ Nervous at the present time

Injury is a result of: (*Circle one choice)*

An ACCIDENT A WORK-RELATED accident A MOTOR VEHICLE accident

Has Accident has been reported to insurance? ❑ Yes ❑ No

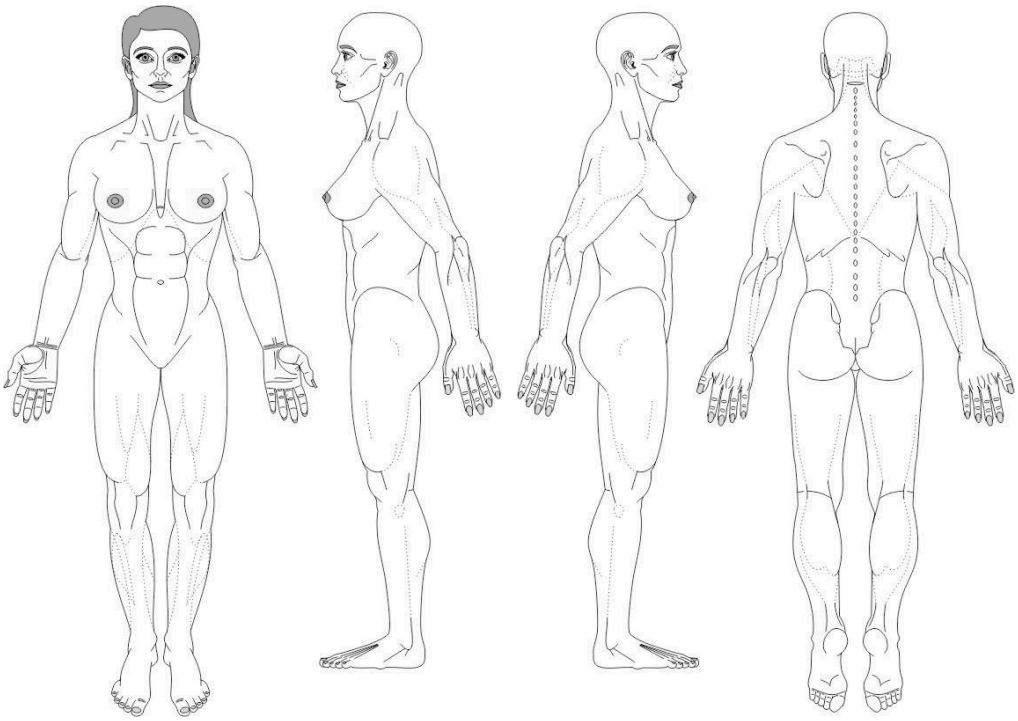
Date of Accident_____ Accident Claim # _____

Insurance Company_____

Insurance Agent_____

Other health concerns you wish to bring to the therapists attention:

Please mark where your area of concern is located on your body on the diagrams below



Health Compliance

Ronghua Bian (Rona) complies with the rules and regulations promulgated by the Department of Health with respect to the proper cleaning and sterilization of needles used in the practice of acupuncture and the sanitation of this acupuncture office. She uses only one-time, single-use needles in her practice.

You, as a patient, are entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known.

You, as a patient, may seek a second opinion from another health care professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registrations in the Department of Regulatory Agencies.

Consent for Acupuncture Care

I, the undersigned, am aware of the benefits and risks of acupuncture and give my consent for treatment. I fully understand that there is no implied or stated guarantee of success or effectiveness of a specific treatment or series of treatments. I further realize that Medicare or Tricare does not cover acupuncture treatment at this time.

It is agreed: With regard to medical care and services, the ATTENDING ACUPUNCTURIST will provide services to the patient and to the best of her skill and knowledge of medical care in the light of circumstances, which is possible and practical. The *PATIENT* will cooperate fully with the acupuncturist by following her instructions.

It is agreed: I agree to hold harmless this acupuncturist or to present any issue or concern of medical malpractice by letter to the acupuncturist. If taken further, it will be decided by neutral arbitration, and therewith give up my right to jury or court trial should an issue arise. Because of the differences in human consultation and response, I understand that there is no way possible to warrant the outcome of such medical care and service.

I also have read the Notice of Privacy Practices in this office.

It is agreed: Occasionally some people experience minor bleeding or a tiny bruise from gently piercing the skin. This does not adversely affect your health. On the contrary, it can promote healing.

Patient's initials _____ Date_____

24 Hour Advance Cancellation Policy

If you must cancel or change your appointment, please be considerate of other patients who need treatment, and notify us at least 24 hours in advance. If you fail to do so, any amount of money that's paid in advance is non-refundable and you may be subject to a $25 charge for late cancellation. (*Exceptions include inclement weather and sudden illness.)*

Please give me your cooperation so I may serve everyone who needs care.

Patient's initials _____ Date_____

Insurance

It is your responsibility to understand the limitations and provisions of your insurance policy. We cannot guarantee your coverage, nor do we establish your deductibles and co-insurance payments. Therefore, all fees not covered by insurance and all co-insurance payments are the responsibility of the patient.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize payment of medical benefits to this acupuncture clinic for services.

I have read and agreed to the proceeding information:

Patient Signature: _____ Date: _____

Protecting Your Health Information and Your Privacy

(This notice describes my office's policy about 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 my office, I may need to share limited personal medical and financial information with your Insurance company, with Workman's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorize.

Safeguards in place at my office include:

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

Types of information that I gather and use:

In administering your health care, I gather and maintain information that may include nonpublic personal information:

- From your medical history, treatment notes, all test results, and any letters, faxes, emails and telephone conversations or from other health care practitioners.
- About your financial transactions with me (billing transactions).
- 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 I have collected about you, (information that can identify you e.g. your name, address, Social Security number, etc.).

I value our relationship, and respect your right to privacy. If you have questions about my privacy guidelines, please call me at (719) 528-6285.

Patient Signature: _____ Date: _____

Authorization to Release Information

I hereby authorize any physician, surgeon, practitioner, registered pharmacist or other person, any hospital, any medical service organization, any insurance company or any other institution or organization to release to you, and you to them, any medical or other information acquired concerning my condition or other disabilities. A copy of this authorization shall be as valid as the original.

Patient Signature: _____ Date: _____