Patient Health Status

Patient Health Status	**File #**
Patient Name: ________________	**Date:**
	Gender: M / F
Last First Middle	**Age:**

Height: _______________ Weight: ___________________

Chielf Complaints	**Please describe your current health problems**

Medical History	**Please check all of following that apply to you**	
☐ Allergy _________________	☐ H.I.V. / AIDS	☐ Seizures
☐ Asthma	☐ Hyperthyroid Disease	☐ Stroke
☐ Arthritis	☐ Hypothyroid Disease	☐ Tumor / Cancer : ________________
☐ Blood Pressure - High / Low	☐ Heart Disease __________________	☐ Self Immune Disease : ____________
☐ Diabetes Type - I / II	☐ Kidney Disease _________________	☐ Sugery : ________________________
☐ H.B.V. / Hepatitis	☐ Pacemaker	☐ Other : _________________________

☐ Alcohol ☐ Drug ☐ Smoking ☐ Vegetarian ☐ Blood Thiner (Aspirin)

Reserved for clinic use

Family History	**Please write donw which family member**		
Name of Disease	**Who**	**Name of Disease**	**Who**
Allergy	______________	Heart Disease ______________	______________
Asthma	______________	Seizures	______________
Blood Pressure - High / Low	______________	Stroke	______________
Diabetes Type - I / II	______________	Self Immune Disease: __________	______________
Hyperthyroid Disease	______________	Tumor / Cancer : ______________	______________
Hypothyroid Disease	______________	Other : ____________________	______________

Current Medications	**Please write down the name and dossage of medicince**

Patient Signature: ________________________ **Date:** ____________

Patient Information

Patient ID # | | | | | | |

Patient Name: ____ **Birthday:** _______________ **Sex** M / F
Last First Middle mm / dd / yyyy

Primary Language: ________________ **Marry Status:** Single / Married / Divorced / Other

Address:_________________________________ City_________________ State _______________ Zip________

Phone # (Home) _______________ (Cell)_______________ (Work)_______________

Email: ____

Employer / Company : ________________________________ **Occupation:** _______________________

Primary Health Plan

PPO EPO HMO

Primary Health Plan: _________________________________ **Patient / Member #** _____________________

Insured Information (If different from patient):

Name: ____ **Birthday:** _______________ **Sex** M / F
Last First Middle mm / dd / yyyy

Address:_________________________________ City_________________ State _______________ Zip________

Phone # _______________ **Relationship to Patient:**____________________

Secondary Health Plan

PPO EPO HMO

Second Health Plan: _________________________________ **Patient / Member #** _____________________

Insured Information (If different from patient):

Name: ____ **Birthday:** _______________ **Sex** M / F
Last First Middle mm / dd / yyyy

Address:_________________________________ City_________________ State _______________ Zip________

Phone # _______________ **Relationship to Patient:**____________________

Are you under the care of a physician? ☐ **No** ☐ **Yes, for what conditons?**______________________________

____

Physicion Name: ____________________________ **Physicion Phone #:** ______________________________

Reserved for clinic use

I certify that the above information is complete and accurate to the best of my knowledge. 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 acupuncture provider may need to contact my other primary care physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my acupuncture provider to contact my medical doctor if necessary.

Patient signature: _______________________________________ **Date:** _____________

<u>Financial Policy</u>

- As a courtesy, we will bill your insurance company if you have acupuncture benefits. We cannot bill health insurance for conditions that are not covered by your plan. **You are expected to pay on the day of service**. If we receive reimbursement for your treatments, they will be applied to your account as a credit or check can be made out to you. Expect payment within 6-8 weeks of the start of your first treatment.

- If the insurance company sends the check to patient in patient's name, patient must **write an equal amounts check and pay to clinic in less than 4 weeks. Patient must return checks to clinic or it will consider medical fraud.**

- A $30 fee will be charged for missed appointment or cancellations without 24 hours notification.

- Payment is due at time of service for non-insurance patients.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

____ ____________

Patient / Guardian Signature **Date**

____

Print name

Informed Consent to Receive Treatment

By signing below, 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 on the patient named below, for whom I am legally responsible) by the acupuncturist(s) who now or in the future treat me. I understand that methods of treatment may include, but are not limited to, acupuncture, ear seeds, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling.

Acupuncture: This is a safe treatment involving the insertion of fine sterile and single use needles through the skin. Treatments can occasionally produce a mild but temporary discomfort, usually achiness, tingling or soreness at the acupuncture site. Treatments can also cause slight bleeding and will rarely leave a non-painful bruise at the acupuncture site. Other possible risks from acupuncture include dizziness and fainting. I agree to come to each session having eaten within the past 3 hours, and I will report to my Licensed Acupuncturist any dizziness or light-headedness that occurs during or after an acupuncture treatment. Extremely rare risks of acupuncture include nerve damage, organ puncture and infection. These risks have an extremely low incidence, especially when acupuncture is administered properly by a Licensed Acupuncturist.

Traditional Chinese Herbal Medicine Treatments: Chinese herbs have been used safely for centuries. Infrequently, one may experience digestive upset or other reactions to herbs. If I experience any discomforts related to the use of any herbs I am prescribed, I understand that I should stop the herbs and that I am responsible for informing my Licensed Acupuncturist of my symptoms. Some herbs may be inappropriate during pregnancy or breastfeeding. I accept full responsibility to inform my practitioner immediately if I am pregnant or breastfeeding, or if I am attempting or suspecting pregnancy. With all herbal treatment, I agree to follow the prescribed dosage and administration guidelines given to me by my acupuncturist. I will inform my practitioner if I am taking any medications, or if there are any changes in my medications, before any herbal treatment is initiated.

Heat Treatments with Heat Pad or Infrared Lamp: These methods are used to warm areas of the body to promote health. Every precaution is taken to prevent over-warming, but the rare possibility of mild burns exists.

Cupping: This technique involves a localized suction produced by heating a glass cup. There is a possibility of local non-painful bruising from this suction. The bruising, which is not painful, usually resolves in 3-14 days. Very rarely a slight burn, hair burn or blister may appear due to the heat.

Electro-Acupuncture: A mild electric micro-current similar to a TENS treatment may be used to stimulate the acupuncture points. A mild tingling or tapping sensation will be felt during treatments. Occasionally a mild achiness or soreness will be felt at the areas treated for up to a day after the treatment. I understand that I must inform my practitioner if I am using a pace maker or have any heart or neurological condition prior to having this treatment.

Acupressure and Massage: Acupressure and massage are used to reduce or prevent pain, and to normalize the body's physiological functions. I will inform my Licensed Acupuncturist of any areas of injury or extreme discomfort, as well as any areas where I have had surgery, prior to any massage. I understand that there may be muscle soreness or achiness as well as the possible aggravation of symptoms existing prior to the treatment during or after massage.

I understand the clinical and administrative staff may review my patient records and lab records but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present conditions and for any future condition(s) for which I seek treatment.

Patients, who are pregnant, have a pacemaker or heart condition; have a seizure disorder, or those with a bleeding disorder or taking blood thinners should discuss this with the acupuncturist before proceeding with acupuncture.

I have read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

____ __________________

Patient / Guardian Signature **Date**

____

Print name

Authorization form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize **Balance Care Wellness Group** to use and/or disclose certain protected health information (PHI) about me to contact with my primary doctor or other medical discussion regarding my health condition.

This authorization permits **Balance Care Wellness Group** to use and/or disclose the following individually identifiable health information about me (name, age, gender, occupation, health information, treatment plan, treatment date and evaluation from the treatment.):

The information will be used or disclosed for the following purpose:

Contact with patient's primary doctor.

Medical discussion regarding patient's treatment plan.

The purposes are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire until I revoked the permission with writing.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from **Balance Care Wellness Group.** In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

Balance Care Wellness Group

130 W Route 66 Suite 312 Glendora, CA 91740

Signed by: ________________________________ ________________________

Signature Date

Signaturae Release Form

Patient Name: ______________________________________

Health provider Name: ________________________________

I certify that the information given by me in applying for insurance Payment is true and correct. I authorize my health provider to act as my agent in helping me to obtain payment of my insurance benefits and I authorize payment of these benefits directly to my health provider on my behalf for any service and materials furnished.

I confirm the release of my authorization to my health provider to have my signature as “signature on file” on my health insurance claim forms.

______________________________________ ______________

Patient / insured / Guardian Signature **Date**

_________________________________ ______________

Health provider Signature **Date**