



# Acupuncture & Herbal Therapies

222 2<sup>nd</sup> Street N, St. Petersburg, FL 33701 (Phone) 727-551-0857

Last Name:	First Name:	Male/Female:	Date of Birth:
Address:	City:	State:	Zip:
Home Phone#:	Cell Phone#:	Email: (for appointment reminders)	
In case of an Emergency Contact:	Relationship:	Phone#:	
Would you like us to bill your insurance? (Please see Financial Policy):			Social Security#:
Occupation:	How did you hear about us? / Referred by:	Family Physician & Phone #:	
MAIN PROBLEM(S) YOU WOULD LIKE HELP WITH:			
How does it interfere with your activities?    When did you first notice your symptoms?			
Have you been given a diagnosis by your family physician?		If so, what is it?	
What kind of treatments or therapies have you tried?			

## HIPAA Patient Consent

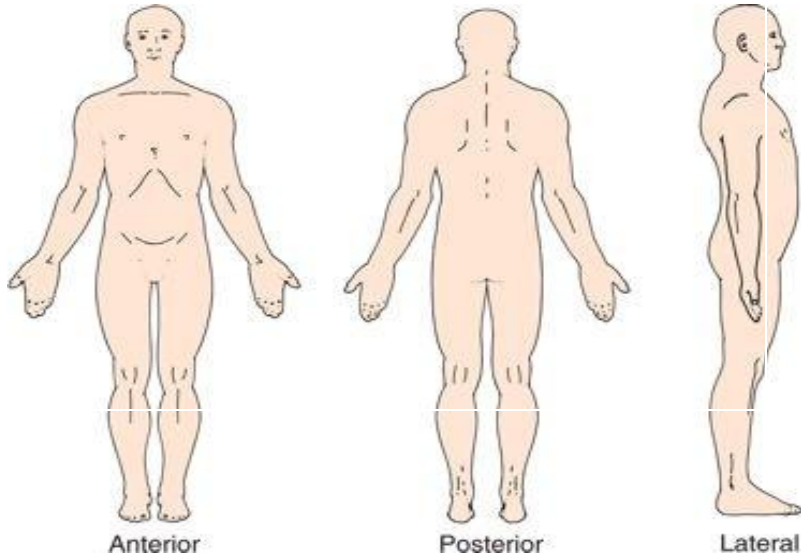
Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The practice may condition treatment upon the execution of this Consent

\_\_\_\_\_  
 Patients Signature Print                  Date

\_\_\_\_\_  
 Witness Signature Print                  Date

PLEASE MARK AREAS OF PAIN OR DISTRESS:



Please mark pain level today:

- 10 Worst imaginable
- 9
- 8
- 7
- 6
- 5 Barely tolerable without medicine
- 4
- 3
- 2
- 1 No problem
- 0 None

Accidents, surgeries, or significant trauma:

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Occupational stress factors:

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PAST MEDICAL HISTORY-please note dates

- Cancer
- High blood pressure
- Thyroid disease
- Hepatitis
- Seizures
- Diabetes
- Heart Disease
- Venereal disease
- HIV/AIDS
- Other significant illness

LIFESTYLE:

What medications or supplements are you currently taking? (dosage/frequency)?

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Please indicate usage per day/per week:

- Cigarettes
- Alcohol
- Drugs
- Caffeine
- Sugar
- Other

Are you on a special diet? Please specify:

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How active are you? Exercise / frequency / intensity?

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**CHECK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST THREE MONTHS.  
INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.**

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**GENERAL**

- |  |   |  |                                 |
|--|---|--|---------------------------------|
| <input type="checkbox"/> Poor appetite                         | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Fever                       | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night sweats                          | <input type="checkbox"/> Cravings           | <input type="checkbox"/> Changes in appetite         | <input type="checkbox"/> Thirst |
| <input type="checkbox"/> Sweating easily                       | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor Balance                | <input type="checkbox"/> Edema  |
| <input type="checkbox"/> Insomnia                              | <input type="checkbox"/> Disturbed sleep    | <input type="checkbox"/> Bleeding or bruising easily |                                 |
| <input type="checkbox"/> Sudden energy drop (time of day_____) | <input type="checkbox"/> Tremors            |  |                                 |

Other unusual or abnormal conditions you have noticed in your general sense of health

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**SKIN AND HAIR**

- |                                      |  |                                  |                                    |
|--------------------------------------|--|----------------------------------|------------------------------------|
| <input type="checkbox"/> Rashes      | <input type="checkbox"/> Moles                                 | <input type="checkbox"/> Itching | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Changes in hair or skin texture, acne |                                  |                                    |

Any other hair or skin problems: (please specify)

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**HEAD, EYES, EARS, NOSE, THROAT**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Recurrent sore throat  | <input type="checkbox"/> Dry eyes            | <input type="checkbox"/> Earaches       |
| <input type="checkbox"/> Sores on tongue/lips   | <input type="checkbox"/> Eye pain            | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Spots in front eyes | <input type="checkbox"/> Facial pain    |
| <input type="checkbox"/> Concussions  | <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Jaw clicks     |
| <input type="checkbox"/> Poor vision/Night blindness                                  | <input type="checkbox"/> Change in taste     | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Headaches, Ear ringing, Hearing loss (where?_____when?_____) |  |   |

Any other head or neck problems: (please specify)

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**CARDIOVASCULAR AND RESPIRATORY**

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> High blood pressure              | <input type="checkbox"/> Fainting   |
| <input type="checkbox"/> Blood clots        | <input type="checkbox"/> Difficulty in breathing          | <input type="checkbox"/> Phlebitis  |
| <input type="checkbox"/> Swelling of feet   | <input type="checkbox"/> Swelling of hands                | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Irregular heartbeat              | <input type="checkbox"/> Asthma     |
| <input type="checkbox"/> Coughing up blood  | <input type="checkbox"/> Pain with breathing              | <input type="checkbox"/> Pneumonia  |
| <input type="checkbox"/> Bronchitis         | <input type="checkbox"/> Excessive phlegm<br>(color_____) |                                     |

**GASTROINTESTINAL**

- Belching, Constipation
- Nausea/Vomiting
- Black stools
- Diarrhea
- Hemorrhoids/Indigestion
- Gas
- Abdominal pain/cramps
- Bad Breath/ Bad taste in mouth

Any other problems with stomach or intestines? \_\_\_\_\_

**GENITOURINARY AND REPRODUCTIVE**

- Pain on urination
- Urgency to urinate
- Blood in urine
- Sores on genitals
- Unable to hold urine
- Kidney stones
- Frequent urination
- Change in sex drive
- Decrease in flow

Do you wake up at night to urinate? \_\_\_\_\_ If so how often? \_\_\_\_\_  
Any particular color to your urine? \_\_\_\_\_ Other problems? \_\_\_\_\_

- Premenstrual changes
- Heavy/Irregular/Light (menses)
- Miscarriages
- Painful menses
- Abortions
- Unusual menses
- Other problems

Are you pregnant now, or trying to become pregnant? \_\_\_\_\_ Age at first menses \_\_\_\_\_  
Age at menopause \_\_\_\_\_ Number of pregnancies \_\_\_\_\_  
Time between cycles \_\_\_\_\_ Duration of bleeding \_\_\_\_\_ First date of last menses \_\_\_\_\_  
Do you practice birth control? \_\_\_\_\_ If so what type? \_\_\_\_\_ For how long? \_\_\_\_\_  
Any other gynecologic problems: \_\_\_\_\_

**MUSCULOSKELETAL**

- Neck pain
- Back pain
- Hip pain
- Hand/wrist pains
- Areas of numbness
- Shoulder pain
- Foot/ankle pains
- Muscle weakness
- Knee pain

Any other problems: \_\_\_\_\_

**NEUROPSYCHOLOGICAL**

- Depression
- Poor memory
- Anxiety
- Easily susceptible to stress
- Lack of coordination
- Bad temper

Have you ever been treated for emotional problems? \_\_\_\_\_  
Have you ever considered or attempted suicide? \_\_\_\_\_  
Any other neurological or psychological problems? \_\_\_\_\_

**COMMENTS**

Please list any other problems you would like to discuss:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Acupuncture and Herbal Therapies

### **Financial Policy:**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. All Patients must complete our Patient Information Sheet before seeing the physician.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER and AMERICAN EXPRESS.

### **Regarding Insurance:**

We do not accept insurance nor do we file claims. We will provide a superbill upon request so that you may file for reimbursement with your insurance. We do not guarantee reimbursement.

### **Usual and Customary Rates (UCR)**

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that, at times, perhaps all the services may be "non-covered" services and not considered reasonable and necessary under your medical insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

### **Missed Appointments:**

Unless canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Your treatments will be more effective if you follow your doctor's guidelines and maintain your treatment schedule. Please help us to serve you better by keeping scheduled appointments.

### **Returns:**

We are unable to refund for any personalized formulas, raw herbs, powdered herbs or outdated herbs. We can refund for patented formulas within 30 days of purchase that are unopened and have no markings on the bottle.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.  
A photocopy of this form shall be considered as effective as the original.

### **Signature of Patient or Responsible Party Date**

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