PATIENT REGISTRATION

PATIENT INFORMATION

Name_____ Sex: ☐ M ☐ F Birthdate_____ Age ____

Address _____ Occupation _____

City _____ Zip_____ Employer _____

How did you hear about us?

☐ Friend (name) _____
☐ Online Search
☐ Website _____
☐ Newspaper Ad
☐ Magazine Ad
☐ Doctor _____
☐ Other _____

CONTACT INFORMATION

(check preferred phone # to reach you)

☐ Home _____ ☐ Cell _____
☐ Work _____ Ext _____
Email Address _____
(email may be used for appt reminders and newsletters but will not be sold to third parties)
Emergency Contact (name) _____
Relationship _____ Phone # _____

PATIENT CONDITION

Reason(s) for Visit _____

When did symptoms begin? _____

How often do you have these symptoms? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

What treatment have you already received for this condition?

☐ Medical ☐ Chiropractic ☐ Massage ☐ None ☐ Other _____

Name and address of health care providers who have treated you for your condition _____

_____

Name and address of primary care physician (if not given above) _____

_____ Phone_____

MEDICATIONS (please list)	ALLERGIES	VITAMINS/HERBS/SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Hospitalizations and/or Surgeries _____

_____

1. **Head, Eye, Ear, Nose, Throat** (please circle any that you have experienced in the past 6 months):

Impaired Vision Tearing/Dryness Impaired Hearing Ear Ringing Earaches

Headaches Sinus Problems Nose Bleeds Teeth Grinding TMJ/Jaw Problems

2. **Respiratory** (please circle any that you have experienced in the past 6 months):

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Asthma Tuberculosis Shortness of Breath

3. **Cardiovascular** (please circle any that you have experienced in the past 6 months):

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure

Palpitations/Fluttering Stroke Heart Murmurs

4. **Gastrointestinal** (please circle any that you have experienced in the past 6 months):

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Excessive Gas Heartburn

Excessive Belching Gall Bladder Disease Liver Disease Hepatitis B or C Abdominal Pain

5. **Genito-Urinary Tract** (please circle any that you have experienced in the past 6 months):

Kidney Stones Painful Urination Frequent UTI Frequent Urination Heavy Flow

Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

6. **Menstrual/Birthing History:**

1. Age of First Menses: _____ 4. Birth Control Type: _____ 7. # of Abortions: _____

2. # of Days of Menses: _____ 5. # of Pregnancies: _____ 8. # of Live Births: _____

3. Length of Cycle: _____ 6. # of Miscarriages: _____

7. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain

Low Back Pain Leg Pain Joint Pain (if so, where?):_____

8. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

9. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

10. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet

Is there anything else we should know?

_____

East Side Acupuncture
Cancellation Policy

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are honored:

24 Hour Advance Notice
Is required when canceling any appointment. This allows the opportunity for someone else to schedule an appointment. If you are unable to give us 24 hours advance notice you may be charged **50% of the amount of** your appointment. This amount must be paid prior to your next scheduled appointment.

No-shows
Anyone who either forgets or consciously chooses to miss their appointment for whatever reason will be considered a "no-show." They may be charged the **full amount** for their "missed" appointment.

Late Arrivals
If you arrive late, your session may be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**. Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time. Likewise, we will do our best to operate in a timely fashion as we respect your time as well.

Insurance Patients
The policies stated above will not be billed to your insurance and are your responsibility to pay out-of-pocket.

We look forward to serving you!

Signature: _____ *Date:* _____

Please print your name and sign both forms on this page

INFORMED CONSENT

I, _____ (name) 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 Casey Lewis and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for Casey Lewis, including those working at East Side Acupuncture, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to: acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), Oriental herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Oriental Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify a clinical staff member who is caring for me if I am or become pregnant.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

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 condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient Signature (or patient representative; indicate relationship if signing for patient) Date

Casey Lewis, LAc _____ _____

Signature Date

ADVISORY TO CONSULT A PHYSICIAN

We, the undersigned, do affirm that _____ (patient name) has been advised by Casey Lewis, Lac,

to consult a physician regarding the condition or conditions for which such patient seeks acupuncture treatment.

_____ _____

(Patient Signature) (Date)

East Side Acupuncture

SUMMARY OF PATIENT PRIVACY POLICY AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

This notice is to inform you that we are in compliance with the law concerning privacy of your health information, HIPAA. This is a short summary; the full length explanation of HIPAA is available to you upon request. If you are concerned about how we may use your information, please read the long version called, "Notices of Privacy Practices." **By signing this form, you acknowledge the understanding of this Notice.**

We, at this clinic, do not share your protected health information (PHI) with anyone other than with an entity that you agree to share information with. By signing this form, you agree to allow us to use your information for pertinent reasons: products and services, healthcare operations including communication with your primary care physician or other health care providers, and billing for payment of products and services. These reasons are fully described in the "Notices of Privacy Practices." This type of information includes your name, social security number, birthdate, address, insurance company, phone numbers, your health history questionnaire, and any and all related medical charting in regards to products or services we provide to you.

Patients can request to have anyone accompany them in the room during treatment. The patient then acknowledges that personal health information may be shared with this person. We do not share your PHI with anyone else in the clinic other than those listed here or pertinent staff of the clinic for the purpose of clinic operations.

We have the right to contact you by phone, mail, or email if you list this information in your consent form. This contact could be regarding scheduling, promotions, or other pertinent reasons of the clinic, but we will not give PHI to anyone else as a result of these types of contact.

_____ _____ _____

Print Name Signature Date

(This form is for patients with insurance coverage only)

Assignment of Benefits

I authorize my insurance benefits to be paid directly to East Side Acupuncture. I understand that I am financially responsible for any charges not covered by my insurance benefits or denied by my insurer.

I authorize the provider to release any information required for the processing of this claim.

Name (print) : _____

Signature: _____ Date: _____