Whole Health Acupuncture

Patient Intake & Assessment Form

Full Name:_____ Sex:___F:_____M:_____Today's Date:_____
Date of Birth:_____Age:_____Occupation:_____
Main Phone #:_____Other Phone #:_____
E-mail Address:_____Email Contact Allowed:_____Y:_____N:_____
Street Address:_____City:_____State:_____Zip:_____
Emergency Contact:_____Phone:_____Relationship:_____
Marital Status:_____# of Children:_____
Do You Have Health Insurance?:_____Y:_____N:_____Company Name:_____
Does Your Insurance Cover Acupuncture?: Y:_____N:_____I Am Not Sure:_____
Have You Been Treated With Acupuncture Before?:_Y:_____N:_____Family Physician Is:_____
Have You Seen Your Family Physician or Chiropractor Within the Last 60 Days?:_____Y:_____N:_____

Main Complaint(s):_____
What Diagnosis, if any, have you received for the above problem?:_____
When did this problem begin?:_____What things induce this problem?:_____
Has this problem interfered with your daily life (work, sleep, sex, emotions)?:_____
What makes this problem better?:_____What makes this problem worse?:_____
What forms of treatment have you tried?:_____
Is there anyone else in your family with this or a similar problems & your relation to them?:_____
Additional information regarding this problem:_____
_____

Medical History

Please check if the condition applies to yourself and/or a family member.

Cancer:_____S:_____F:_____Breathing Problems:_____S:_____F:_____Tuberculosis:_____S:_____F:_____
Diabetes:_____S:_____F:_____Heart Disease:_____S:_____F:_____High Cholesterol:_____S:_____F:_____
Hepatitis:_____S:_____F:_____Digestive Disorders:_____S:_____F:_____High Blood Pressure:_____S:_____F:_____
Anemia:_____S:_____F:_____Venereal Disease:_____S:_____F:_____Emotional Disorders:_____S:_____F:_____
Seizures:_____S:_____F:_____Thyroid Disease: _____S:_____F:_____Alcoholism:_____S:_____F:_____
Arthritis:_____S:_____F:_____Other(s):_____
Surgeries:_____
Hospitalization:_____
Significant Trauma (auto accident, sports injury, etc.):_____
Allergies (drugs, food, chemical, latex, environmental):_____

Medications

Please list all medications taken within the last 60 days, including; herbs, prescription & OTC drugs, vitamins, supplements & their dosages, how often they were taken, & what for/diagnosis.

_____
_____
_____

Occupation

Hours:_____Indoors or Outdoors:_____Desk or Standing or Lifting:_____
Occupational Stress (chemical, environmental, physical, emotional):_____
Years in this profession:_____Are you a student?:_____

Personal

Height:_____ Weight:_____ Heaviest Weight & When:_____ Lightest Weight & When:_____
Smoker:_____ How many per day:_____ How long have you smoked:_____
Do you exercise regularly?:_____ What type(s) of exercise:_____
Hours of sleep:_____ Time to bed:_____ Time awake:_____
Do you feel your sleep is well and/or enough?:_____ Hours in front of a screen (T.V. or computer):_____

Diet

Coffee (cups/day):_____ Tea (cups/day):_____ Soda (#/day):_____ Water (cups/day):_____
Type of alcoholic beverage, if any:_____ Average per week:_____
Vegetarian:_____ Y:_____ N:_____ Y, but not strict:_____ Spicy Food:_____ Y:_____ N:_____
Dairy:__ Y:_____ N:_____ Additional Nutritional Information:_____
Please describe your average daily diet, as specifically as possible.
Morning:_____
Afternoon:_____
Evening:_____
Snacks:_____

Additional Detailed Health Conditions

Please check any that you have experienced within the last 60 days.

General

Poor Appetite:_____ Poor Sleep:_____ Fatigue:_____ Fevers:_____ Chills:_____
Night Sweats:_____ Sweat Easily:_____ Change in Appetite:_____ Cravings:_____ Tremors:_____
Poor Balance:_____ Bleed or Bruise Easily:___ Localized Weakness:_____ Weight Loss:_____ Weight Gain:____
Peculiar Tastes:_____ Desire for Hot Food:_____ Desire for Cold Food:____ Strong Thirst for Hot/Cold Drinks:_____
Sudden Drop in Energy, what time of day:_____ Favorite Time of Year:_____ Worst:_____

Skin & Hair

Rashes:_____ Ulcerations:_____ Hives:_____ Itching:_____ Eczema:_____
Pimples:_____ Acne:_____ Dandruff:_____ Dry Skin:_____ Hair Loss:_____
Recent Moles:_____ Purpura:_____ Nail Fungus:_____ Scalp Fungus:_____ Foot Fungus:____
Change in Hair or Skin Texture/Other:_____

Musculoskeletal

Joint Disorders:_____ Muscle Weakness:_____ Pain/sore Muscles:_____ Tremors:_____ Tingling:_____
Cold Hands/Feet:_____ Difficulty Walking:_____ Swelling of Hands/Feet:__ Hernia:_____ Paralysis:_____
Spinal Curvature:_____ Back Pain:_____ Neck Tightness:_____ Neck Pain:_____ Hip Pain:_____
Shoulder Pain:_____ Hand/Wrist Pain:_____ Knee Pain:_____ Heel Pain:_____ Joint Sprain:____
Vertebral Disk Herniation/Where:_____ Other:_____

Head, Eyes, Ears, Nose, Throat

Eye Strain:_____ Eye Pain:_____ Dizziness:_____ Concussions:_____ Migraines:_____
Glasses/Lens:_____ Color Blindness:_____ Night Blindness:_____ Poor Vision:_____ Cataracts:_____
Blurry Vision:_____ Earaches:_____ Ringing in Ears:_____ Poor Hearing:_____ Sore Throat:____
Spots in Front of Eyes:___ Sinus Problems:_____ Nose Bleeding:_____ Sore Lips/Tongue:_____ Facial Pain:_____
Difficulty Swallowing:___ Grinding Teeth:_____ Teeth Problems:_____ Jaw Pain:_____ Jaw Clicks:_____
Other:_____

Cardiovascular

High Blood Pressure:____ Low Blood Pressure:____ Chest Pain:_____ Palpitations:_____ Phlebitis:_____
Irregular Heart Beat:_____ Rapid Heart Beat:_____ Slow Heart Beat:_____ Varicose Veins:_____ Fainting:_____
Edema:_____ Other:_____

Respiratory

Cough:_____ Coughing Blood:_____ Difficulty Breathing:____ Wheezing:_____ Bronchitis:_____
Asthma:_____ Pneumonia:_____ COPD:_____ Emphysema:_____ Chest Pain:_____
Production of Phlegm/What Color:_____ Other:_____

Gastrointestinal

Nausea:_____ Vomiting:_____ Diarrhea:_____ Constipation:_____ Gas:_____
Belching:_____ Black Stools:_____ Blood in Stools:_____ Indigestion:_____ Bad Breath:_____
Abdominal Pain:_____ Hemorrhoids:_____ Gallbladder Problems:____ Rectal Pain:_____ Parasites:_____
Chronic Laxative Use:____ Chronic Antacid Use:____ Acid Reflux:_____ Burning Sensation:_____ Bloating:_____
Bowel Movements:_____ Frequency:_____ Texture/Form:_____ Color:_____ Odor:_____
Other:_____

Neurological Psychological

Loss of Balance:_____ Lack of Coordination:____ Concussion:_____ Depression:_____ Anxiety:_____
Stress:_____ Bad Temper:_____ Bi-Polar:_____ Weepy/Cry Easily:_____ Irritable:_____
Numb/Tingling Limbs:___ Other:_____

Genito-urinary

Painful Urination:_____ Frequent Urination:_____ Night Urination:_____ Urgency to Urinate:_____ Dribbling:_____
Frequent UTI:_____ Unable to Hold Urine:____ Inconsistent Flow:_____ Blood in Urine:_____ Genital Pain:____
Genital Itching:_____ Genital Rashes:_____ STDs:_____ Kidney Stones:_____ Bladder Stones:__
Other:_____

Female

Frequent Vaginal Infections:_____ Pain/Cramps Prior to/During Periods:_____
Frequent Yeast Infections:_____ Vaginal/Genital Discharge/Color:_____
Moodiness Related to Periods:_____ Breast Tenderness/Discharge/Lumps:_____
Pelvic Infection:_____ Endometriosis:_____ Fibroids:_____ Ovarian Cysts:_____ Clots/Color:____
Irregular Periods:_____ Fertility Problems:_____ Hot Flashes:_____ Sexual Partners:_____ Painful Sex:____
First Date of Late Period:_____ Age of First Period:_____ Duration of Periods:_____ Cycle Days:____
Do You Practice Birth Control?:_____ If Yes, What Type?:_____
If You're on Birth Control Medication, What Kind & For How Long Have You Been On It?:_____
Pregnancies:_____ # Births:_____ # Miscarriages:_____ # Abortions:_____ # Premature:____
C-Sections:_____ # Difficult Births:_____ # of Children:_____ Other:_____

Male

Prostate Problems:_____ Testicular Lumps:_____ Erectile Dysfunction:____ Fertility Problems:_____ Discharge:_____
Testicular Pain/Swelling:_____ Ejaculation Problems:____ Frequent Seminal Emission:_____
Night Emission:_____ Other:_____

Are there any other health issues or concerns you would like to address?

_____
_____
_____
_____
_____
_____

I have completed this form to the best of my knowledge. Patient:_____ Parent/Guardian:_____ Spouse:_____

Signature:_____

We greatly appreciate your business & referrals!
Thank you for choosing Whole Health Acupuncture!

Whole Health Acupuncture

24 Hour Cancellation Policy

An Acupuncture appointment at this clinic is viewed as a commitment and connection between the Acupuncturist and the Patient.

There is a full visit fee for missed appointments without 24 hour notice. 48 Hour advance cancellation is **preferred** and **24 is required**. A **credit card is required** to secure the appointment.

If you are unable to keep your appointment, please notify me as soon as possible. The answering machine is on 24 hours a day. Because I do not double-book appointments, when you break your appointment, I am not able to fill the empty spot (unless, at least 24 notice is given). As time and space can be limited someone else may not be able to have been seen by me. I value your time, so please value mine as well.

If your schedule is hectic or you are not sure if you can keep your appointment, inform me and we can reschedule it. Thank you for your understanding and cooperation.

Patient Name (print)	Date
Patient/Guardian Signature	CC Type
CC #	CC Expiration
Billing Zip	

Whole
Health
Acupuncture

Confidentiality Agreement
HIPPA Acknowledgement and Appointment Reminders Form

I acknowledge that I have been provided access to Whole Health Acupuncture's Privacy Policy Notice. I understand that I have the right to review Whole Health Acupuncture's Privacy Policy Notice prior to signing this document.

I understand that Whole Health Acupuncture's staff may need to contact me with appointment reminders or information related to my treatments. If this contact is to be made by phone, and I am not at home, a message will be left on my answering machine or with anyone who answers the phone.

Information stripped of any personal identifiers may also be used for research and educational purposes by me, Lisa Lapwing. By signing this form, I am giving Whole Health Acupuncture authorization to contact me with these reminders and to utilize my information for research and educational purposes.

Patient Name (print)	Date
Patient/Guardian Signature	Whole Health Acupuncture Rep

Whole Health Acupuncture

Informed Consent to Oriental Medical Health Care

I hereby request and consent to the performance of the following on myself (or the patient named below, for whom I am legally responsible) by Lisa Lapwing who now or in the future will treat me with the following procedures including diagnostic techniques such as questioning, pulse evaluation, palpation on a variety of areas of my body, observation, acupuncture, range of motion, muscle and orthopedic testing; modes of manual or physical therapy such as body work, manipulation of joints and/or viscera, heat and/or cold therapy and electrical and/or magnetic stimulation; cupping and/or moxibustion; gua sha; the prescription of herbal and homeopathic medicines as well as dietary supplements; dietary recommendations; exercise advice and healthy lifestyle recommendations.

I understand I have opportunities to discuss with Lisa Lapwing the nature and purpose of acupuncture and Oriental medical procedures. Although I am aware that acupuncture and the other procedures used in Oriental medicine have helped millions of people, I understand that no guarantee of cure or improvement in my condition is given or implied.

I understand and am informed that, as in the practice of conventional Western medicine, in the practice or Oriental medicine there are some risks to treatment. I understand that although these risks are unlikely to occur, they are possible. I understand that these risks include, but are not limited to: bleeding, bruising, pain or other strong sensation at the location of where a needle is inserted or radiating from that location, nerve pain, burns, aggravation of current symptoms, appearance of new symptoms and general aches. Other uncommon but possible risks include pneumothorax (punctured lung), puncture of other organs, sprains, dislocation, fractures, disc injuries and strokes. I do not expect Lisa Lapwing to be able to anticipate and explain all risks and complications, and I wish to rely on Lisa Lapwing to exercise such judgment, during the course of my treatment, as she feels at the time, based on the facts then known, to be in my best interest.

I have read, or I have had read to me, this informed consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures and conditions of treatment. 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 with Lisa Lapwing.

_____ _____

Patient's Name (please print) Patient/Guardian Signature

_____

Date

Whole Health Acupuncture

Notification Form Regarding Evaluation of Patient by Physician

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care". As a result, Whole Health Acupuncture is required to have you respond to the following statements before you may be treated. Please be advised that I will not be permitted to treat you with acupuncture if your response to all of these statements is no.

(Pursuant to the requirements of 22 TAC §183.7 of the Texas State Board of Acupuncture Examiners' rule (relating to Scope of Practice and Tex. Occ. Code Ann., §205.351, governing the practice of acupuncture.)

I (patient's name)_____am notifying Whole Health Acupuncture/Lisa Lapwing of the following:

_____Yes_____No. I have been evaluated by a physician or dentist for the condition being treated within 12 months before the acupuncture was performed. I recognize that I should be evaluated by a physician or dentist for the condition being treated by the acupuncturist.

OR

_____Yes_____No. I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after 2 months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, It is my responsibility and choice whether to follow this advice.

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

_____Chronic Pain
_____Smoking Addiction
_____Weight Loss
_____Alcoholism
_____Substance Abuse

_____

Patient/Guardian Signature Required Date

Whole Health Acupuncture/Dr. Lisa Lapwing (FL), LAc. (TX) is not responsible for untrue statements made by patients.

Whole Health Acupuncture

Privacy Policy Notice

I am dedicated to providing service with respect for human dignity. Protecting your privacy and healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in law.

I gather personal information and health information in several ways:

- Information I receive from you.
- Information I receive from other healthcare providers.

This information is used for treatment, payment and healthcare operations. You should be aware that during the course of our relationship, I will likely use and disclose health information about you for the treatment, payment, and healthcare operations. I will only use and/or disclose your protected health information when the law allows me to do so. Any other use and disclosures will be made only with your authorization and, in those instances; you have the right to revoke that authorization. And if so, that authorization would be honored, where legal to do so, from that date forward.

Treatment: For example, from time to time, I may decide that it is medically necessary to refer you to a specialist for additional care. I will need your medical information in order to be able to treat you and that is why we send out your records.

Payment: Many patients utilized medical insurance that pays for treatment. The insurers require your medical information to know how to pay me for your care and that is why we send out your records.

Health Care Operations: I am allowed to disclose your medical information if that it necessary for me to function efficiently. There are also times when I may need the help of a special vendor, such as a medical billing specialist, and I would then send your records to that vendor in order for me to carry on my practice.

You may specifically authorize me to use protected health information for purpose or to disclose our health information by submitting the authorization in writing. Such disclosures will be made to any personal representation you choose to have your Protected Health Information sent to.

Marketing

I will not use your health information for marketing communications without your written authorization. I may send birthday cards, holiday cards, thank you cards, newsletters and appointment reminders, by calls, postcards, letters or emails.

Disclosure

I may use or disclose your Protected Health Information when required by law. This includes but is not limited to Public Health needs, Health Oversight requirements, and issues of abuse or neglect, legal proceedings.

Patient Rights

- **Upon written request you have the right to access, review or receive copies of your healthcare records.** Exceptions are: 1) psychotherapy notes; 2) information I gather in preparation of an administrative action or proceeding; 3) data that is subject to certain provisions of the Clinical Laboratory Improvements Act. I may deny your request (in writing) under certain limited circumstances. Generally, if I agree to provide you with a copy of your records, I will do so within 15 days after your ask for them. I will charge you a reasonable, cost-based fee for the records.
- **Upon written request you have the right to receive a list of items I have disclosed about your healthcare information.** I am required to give you that data except for any use or disclosure: 1) for treatment, payment and/or health care operations; 2) made with your authorization; 3) that I make to you; 4) for any national security or intelligence purposes; 5) made before February 14, 2011; or 6) that does not require your authorization. I will provide this date for you (generally within 60 days) at no charge once each year, but after that, I will require that you pay a reasonable fee-based charge for the information.
- **You have the right to request that I place additional restrictions on disclosure of your Protected Health Information.** You may ask that I limit the use and disclosure of your Protected Health Information; I am not required to accept your request. If we do agree, however, I will do as you wish except in an emergency. You may submit your request to me in writing and tell me: 1) what information you want me to limit 2) how you want me to limit that data and 3) to whom I am to limit the access of this data.
- **You have the right to request that we amend your Protected Health Information; the request must be in writing.** I have the right to deny that request if you ask about medical information that 1) was not created by me; 2) the information is not part of the medical or billing records; 3) is not part of the records you may access or 4) the medical information is accurate and complete. I may ask that you tell me, in writing, why you want me to amend your medical information. Generally, I must act up on your request within 60 days after receipt of your request. If I agree to your request, I must make the appropriate amendment and follow the law regarding how and whom I inform about this amendment. If I do not agree, then I will tell you my reasons. You then have additional rights, including an appeal (by someone who did not participate in the decision not to allow you to amend your record) and you have the right to submit a written statement of disagreement.
- **You have the right to receive all notices in writing.**

_____ _____

Patient's Signature Date

If you have questions, complaints or want more information contact:

Dr. Lisa Lapwing, (FL), L.Ac. (TX)
Whole Health Acupuncture
708-707-0383
lisa@whole-healthacupuncture.com

Send a written complaint to the U.S. Department of Health and Human Services.

This notice is effective as of February 14, 2011. From time to time, I may revise this Notice. If I do, I will have the most current version and you may ask for a copy of the notice at anytime.

Whole Health Acupuncture

Patient Financial Responsibility Form

Thank you for choosing our services for your healthcare needs. I am committed to providing you with the highest quality care. I ask that you read and sign this form to acknowledge your understanding of our patient financial policy.

Patient Financial Responsibilities

• The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
• If possible, I will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
• The patient (or patient's guardian, if a minor) is responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatment not covered by their insurance plan.
• Co-pays are due at the time of service.
• Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing.
• Patients may incur, and are responsible for, payment of additional charges, if applicable. These charges may include, but are not limited to: Charge for returned checks - $30.00.

By my signature below, I hereby authorize assignment of financial benefits directly to Whole Health Acupuncture and any associated healthcare entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. Failure to pay my charges may postpone further treatments, and force Whole Health Acupuncture to refer delinquent balances to an outside third party collection agency. I understand that referring my delinquent balance may affect my credit rating.

Patient Name:_____

Patient/Guardian Signature:_____

Date:_____

NOTE:
I have contracted with Spectra Health Services (SHS) for billing and collection services as an extension of my organization.
Billing questions and concerns should be directed to their office at 626-768-3120. When you receive a statement from me and have questions about your account, you can call SHS. They will be happy to answer your questions, or address your concerns.