North Scottsdale Acupuncture

Name____Date:____________Address____

____Phone_________________________________(Cell or Home?)

Email____ Weight ______ DOB____/_____/______Occupation____________________________

Emergency notify: ____ Emergency phone number: __________________________

How did you hear about us? _________________________________ Would you like to receive our newsletter? __yes___no

CONTACT INFORMATION

Please indicate how we may contact you:

Home yes / no Telephone # _____________________ Messages may be left: yes / no

Work yes / no Telephone # _____________________ Messages may be left: yes / no

Cell phone yes / no Telephone # _____________________ Messages may be left: yes / no

Please check all that apply in the last 6 months:

Musculo-Skeletal:
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Joint Pain
- ☐ Muscle Spasms / Cramps
- ☐ Arm Pain
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Leg Pain
- ☐ Osteoporosis
- ☐ Arthritis

Cardiovascular Conditions:
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Edema

Emotional:
- ☐ Clinical Depression
- ☐ Mild Depression
- ☐ Schizophrenia
- ☐ Mood Swings
- ☐ Panic Attacks
- ☐ Anxiety

Energy & Immunity:
- ☐ Chronic Fatigue Syndrome
- ☐ General Fatigue
- ☐ Slow Wound Healing
- ☐ Easy Bruising
- ☐ Chronic Infections
- ☐ Frequent Allergies

Respiratory:
- ☐ Pneumonia
- ☐ Asthma
- ☐ Frequent Common Colds
- ☐ Difficulty Breathing
- ☐ Persistent Cough
- ☐ Tuberculosis
- ☐ Shortness of Breath

Head, Eye, Ear, Nose & Throat:
- ☐ Eye Pain/Strain
- ☐ Glaucoma
- ☐ Tearing / Dryness
- ☐ Impaired Hearing
- ☐ Ear Infections
- ☐ Headaches
- ☐ Migraine
- ☐ Sinus Problems
- ☐ Nose Bleeds
- ☐ Teeth Grinding
- ☐ TMJ / Jaw Problems

Genito-Urinary Tract:
- ☐ Kidney Disease
- ☐ Painful Urination
- ☐ Frequent UTI
- ☐ Frequent Urination

Neurological:
- ☐ Vertigo / Dizziness
- ☐ Numbness / Tingling
- ☐ Loss of Balance
- ☐ Seizures / Epilepsy

Gastrointestinal:
- ☐ Stomach Ulcers
- ☐ Nausea / Vomiting
- ☐ Epigastric / Abdominal Pain
- ☐ Gas or bloating
- ☐ Reflux
- ☐ Gall Bladder Stones
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea

Endocrine:
- ☐ Hypothyroid
- ☐ Hypoglycemia
- ☐ Hyperthyroid
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Night Sweats
- ☐ Unusual Sweating
- ☐ Low libido

Liver Conditions:
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Gall Bladder:
- ☐ Removed
- ☐ Pain

Other:
- ☐ Cancer Type:______________
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Candida
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema / Hives
- ☐ Cold Hands / Feet

Reason for your visit here today: ____

Diagnosed by a MD? ☐ No ☐ Yes (Diagnosis: ___________________________) How long have you had this condition? ____________

How does this condition affect you? ____

Were you referred here by a medical provider? If so, please enter their name and specialty: ____

Do you currently have any infectious diseases? ☐ Yes ☐ No ☐ Possibly If Yes, please identify:: ______________________________

Please list all prescription and over the counter medications you are currently taking *(Use additional paper if necessary):*

Drug Name	Reason for taking	For how long

NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have received, reviewed and understand the Notice of Privacy Practices. These can always be reviewed again online at NorthScottsdaleAcupuncture.com under Intake Forms.

Signature: ____ Date: ___/_______/______

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated by a Licensed Acupuncturist.

***Initial here*_____ Acupuncture:** I understand that acupuncture is performed by the insertion of single use sterile needles through the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture is typically a safe method of treatment; however certain adverse effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

***Initial here*_____ Pregnancy:** I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

***Initial here*_____ Chinese Herbs:** I understand that Chinese medicinal herbs may be recommended to me to treat bodily dysfunction or diseases, to reduce or prevent pain, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, nausea & vomiting, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Nancy Brem as soon as possible.

Initial here*_____ Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful. However certain adverse effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

I do not expect Nancy Brem to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all 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 of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

Signature: ____ Date: ___________________

Printed Name: ____Date of Birth: _______________

INSURANCE BILLING AUTHORIZATION:

I authorize and direct that my insurance benefits be paid directly to North Scottsdale Acupuncture. I realize that I am responsible to pay for any non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers for the purposes of payment for services I receive from North Scottsdale Acupuncture.

Signature: ____Date: ____/___/______

PRIMARY INSURANCE:

Insurance Company: ____

Name of insured: __________________________________ Insured's date of birth: ___/____/_____

Address of Insured (If different from patient)

____

____

Name of employer:_____________________________ Member ID____________________________________

Group number: ___________________________________ Relationship to Insured: ___________________________

FINANCIAL POLICY:

I understand that I am responsible to pay for any non-covered charges. Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. Please notify us of changes in your insurance. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.
4. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
5. Acupuncture is often billed as a specialist, if we do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
6. We require 24-hour notice for canceling any appointments. There is a **$25** charge for weekday appointments canceled later than 24 hours prior.
7 Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name____Date______________________