DEMOGRAPHICS

Please print and fill out all sections below with as much information as possible, if you have questions feel free to ask for assistance

Name: _____
(first) *(Middle)* *(Last)*

E-Mail Address:_____

Address:_____
Mailing City State Zip

Date of Birth: _____ **Age**: _____ **Gender**: _____ **SSN**: _____

Marital Status: Married: _____ Single: _____ Significant other: _____

Occupation: _____ **Employer**: _____

Phone: Home: (_____)_____ Work: (_____)_____ Cell: (_____)_____

Emergency contact: _____ Phone: (_____)_____ Relationship: _____

How did you hear about the clinic? (Friend family etc.): _____

INSURANCE INFORMATION

Primary Insurance Company: _____ **Subscriber ID:**_____

Secondary Insurance:_____ **Subscriber ID:**_____

*** Attn. VA patients: Subscriber ID and Choice ID are the same**

If you are ***not*** the policy holder on the account, please fill out the following

Insured Name: _____
(first) *(Middle)* *(Last)*

Insured DOB: _____/_____/_____ **Insured SSN**: _____

Address: _____
City State Zip

Phone: Home: (____)_____ Work: (____)_____ Cell: (____)_____

X_____
Patient/Guardian Signature Date

Relationship to patient:_____

I authorize the release of any and all information including the diagnosis and the records of any treatment or examination rendered to my children or myself during the period of such care to third party payers. I realize that failure to keep this account current may result in Sitting Swan LLC being unable to provide additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any further outstanding balance.

X_____
Patient/Guardian Signature Date

HEALTH HISTORY

My 3 main health goals are:

1._____

2._____

3._____

When is the last time you remember feeling truly healthy: _____
_____
Current Health Concerns: _____
Past Treatments: _____
_____

Height: _____ Weight (currently): _____ (past max): _____ When? ____/____/____

Blood pressure (most recent): _____/_____ When? ____/____/____

Are you pregnant, or is there a possibility of being pregnant? Y N
If yes, please explain: _____
_____
Do you have a history of any chronic infectious disease? Y N
If yes, please explain: _____
_____

Please list any know food, drug or medication that you are allergic or hypersensitive to: _____
_____
Please list any prescription medications you are currently taking: _____
_____
Please list any vitamins, minerals and/or herbal supplements you are taking: _____
_____
Are you coming in for work related injury?: Y N Auto accident?: Y N
Are you currently receiving health care under a qualified health care provider?: Y N
If Y: When, where and with whom did you last receive health care or a routine examination?: _____
_____
_____
_____
If N: When were you last evaluated by a health care provider?: _____
For what reason? _____
_____

Relevant Family Health History (for example heart disease, stroke, diabetes, mental illness, common hereditary diseases)_____
_____
_____
_____
_____
_____
_____
_____
_____

Childhood Illnesses
- ☐ Chicken Pox
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic Fever
- ☐ Scarlet fever
- ☐ Diphtheria
- ☐ Other _____

Immunizations
- ☐ Polio
- ☐ Tetanus
- ☐ Measles/mumps/rubella
- ☐ Flu
- ☐ Diptheria
- ☐ Pertussis
- ☐ Other _____

Cardiovascular
- ☐ Heart disease
- ☐ Palpitations
- ☐ Heart Murmurs
- ☐ Hypertension
- ☐ Chest Pain
- ☐ Stroke
- ☐ Other _____

Gastrointestinal
- ☐ Gas
- ☐ Bloating
- ☐ Nausea/Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Appetite Changes
- ☐ Epigastric/abdominal pain
- ☐ Belching
- ☐ Gallbladder disease
- ☐ Heart Burn
- ☐ Other _____

Genitourinary Tract
- ☐ Painful urination
- ☐ Frequent Urination
- ☐ Impaired Urination
- ☐ Night time urination
- ☐ Blood in urine
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Sexually transmitted disease
- ☐ Other _____

Musculoskeletal pain/injury
- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Leg
- ☐ Back
- ☐ Muscle/Cramps/Spasms

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

Endocrine
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Night Sweats
- ☐ Diabetes
- ☐ Hypoglygemia
- ☐ Other _____

Emotions
- ☐ Anxiety
- ☐ Depression
- ☐ Fear
- ☐ Worry
- ☐ Grief
- ☐ Anger
- ☐ Irritability
- ☐ Frustration

Bad Habits
- ☐ Alcohol
- ☐ Caffeine
- ☐ Nicotine
- ☐ TV
- ☐ Other _____

Eyes/Ears/Nose/Throat
- ☐ Poor vision
- ☐ Dry Eyes
- ☐ Eye Pain
- ☐ Glaucoma
- ☐ Glasses
- ☐ Other _____
- ☐ Ringing in ears
- ☐ Ear Aches
- ☐ Hearing Loss
- ☐ Ear Infections
- ☐ Other _____
- ☐ Sinus Problems
- ☐ Nose bleeds
- ☐ Chronic sinusitis
- ☐ Allergies
- ☐ Nasal Discharge (color, amount)_____
- ☐ Other _____
- ☐ Sore throat
- ☐ Dry throat
- ☐ Itchy Throat
- ☐ Other _____

Other diseases and disorders
- ☐ Cancer
- ☐ Anemia
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other _____
- ☐ Other _____
- ☐ Other_____

Female Reproductive Health
- ☐ Irregular cycles
- ☐ Heavy flow
- ☐ Menopausal Symptoms
- ☐ Difficulty Conceiving
- ☐ Breast lumps
- ☐ Cramping
- ☐ Breast tenderness
- ☐ Nipple discharge
- ☐ Decreased Libido

Age of 1st menses: _____
Days of Flow: _____
Length of cycle: _____
Color: _____
Pregnancies: _____
Miscarriages: _____
Abortions: _____
Libido:_____
- ☐ Other _____

_____
_____
_____
_____

Male Reproductive Health
- ☐ Sexual Difficulties
- ☐ Prostate Problems
- ☐ Painful urgent urination
- ☐ Testicular pain
- ☐ Penile Discharge
- ☐ Other _____

Libido level: _____

CONSENT TO TREATMENT

I, _____ (Print name), have requested to be treated by a licensed acupuncturist, which may include but is not limited to one or more of the following modalities of Oriental medicine: acupuncture, herbal consultation, moxibustion, cupping, gua sha, and/or Asian bodywork like shiatsu or tuina, and I (_____ *initial*) acknowledge that I have read or heard and understand the entire form. All of my questions have been answered and I will follow the guidelines presented, and hereby consent to said treatment.

ACUPUNCTURE refers to the insertion and stimulation of specialized needles at specific points along the meridians of the body, with the intention of preventing or managing the course of physical, emotional and/or environmental disease. Acupuncture stimulation includes mechanical (the use of electro-acupuncture, or ion cords) and manual techniques. Electro-acupuncture uses a machine with a nine-volt battery to transmit a small electrical current through the body to create a therapeutic effect. With acupuncture there may be minor bruising, bleeding, or aggravation of symptoms

HERBAL CONSULTATION refers to the differential diagnosis and recommendation of herbal treatment based on Oriental medical and/or Chinese medical theory

MOXA refers to the burning of an herb (also called mugwort or Artemisia vulgaris) over the skin, or on a needle to illicit a therapeutic warming reaction at specific points on the body.

CUPPING refers to the application of a glass cup onto the skin to create a suction and assist in relaxing the muscles at a deeper level. A small flame will be momentarily placed under the cup before placement onto the skin, which will create a decrease in atmospheric pressure inside the cup as the oxogen is burned, and when the cup is then placed onto the skin this will create a desired suction.
GUA SHA refers to the use of a Chinese soup spoon to break up adhesions and stagnation along the meridians of the body.
SHIATSU and TUINA MASSAGE are forms of Asian bodywork that are designed to create relaxation and relief of musculoskeletal discomfort.

I further understand that acupuncture, herbs or any other modality listed above should not be a replacement or substitute for the primary care, diagnosis, and/or the prescription drug recommendations of a doctor, or primary care physician (PCP). (_____ *initial*)
It will also be my responsibility to follow these simple guide lines: (_____ *initial*)
• Report to the acupuncturist any unusual feelings, changes or limitations to including pain or discomfort experienced before, during and/or after treatment. (_____ *initial*)
• Report any and all medical conditions or health concerns to the acupuncturist and a PCP, especially bleeding disorders, the use of a pace maker, infectious diseases, pregnancy, diabetes, hypertension, heart disease etc. (_____ *initial*)
• Report any undesirable reactions to herbal treatment, which may or may not be related to herb-drug or herb-herb interactions. (_____ *initial*)
• Inform the acupuncturist of any changes to medication or treatment by PCP. (_____ *initial*)
• Inform the acupuncturist if you're pregnant or possibly pregnant. (_____ *initial*)
• Do not participate in treatment on an empty stomach I am therefor recommended to eat no earlier than three hours before treatment. (_____ *initial*)
• Do not participate in treatment if under the influence of drugs or alcohol. (_____ *initial*)
• Make 24 hour notice of cancelation other wise I agree to pay the full cost of treatment if I am unable to attend treatment. (_____ *initial*)

X_____
Patient/Guardian Signature Date

Relationship to patient:_____

X_____
Signature of acupuncturist Date

PAYMENT FOR SERVICES POLICY

Please read, initial where indicated, and sign

INSURANCE BILLING

-Insurance coverage does not guarantee payment (_____ *initial*)
-We will bill your insurance if you present your insurance card(s) at the time of your appointment, it is important for you to understand that you are responsible for monitoring the processes of your claim and that you are ultimately responsible for payment of services rendered (_____ *initial*)
-Any co-payments or ''patient responsibility'' must be paid at the time of service (_____*initial*)
- **If we do not receive a response from your insurance company within sixty days from the date we bill them, the balance will become your responsibility** (_____ *initial*)
- You will receive a statement for any remaining for any remaining balance after all applicable insurances have been applied. The balance is due in full at that time (_____ *initial*)

We will inform you when we know a procedure will not be covered, but it is not always possible for us to know with certainty, as this varies greatly among insurance companies and personal policies, and because they will not make a final determination until they have received the claim.

AUTHORIZATION TO PAY BENEFITS TO NAMED ACUPUNCTURIST: I hereby authorize and direct payment of the acupuncture benefits otherwise payable to me, directly to Sitting Swan LLC

X _____
Please sign if your insurance or VA benefits are expected to cover your visit

PATIENT RESPONSIBILITY AND PAYMENT
We accept cash, check, VISA, and Mastercard. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment ***in full*** at the time of service is required in the following circumstances:
-You do not have insurance coverage - You have not provided your insurance information - Your insurance benefits have maxed for the year -Any procedures we believe are not covered

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim

X_____
Patient Signature (or financial responsible party) Date

RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, _____ (Print name), verify that I received the Notice of Privacy Practices from Sitting Swan Acupuncture and Healing Center.

X_____
Patient/Guardian Signature Date

Relationship to patient:_____

Notice of Collection Practices

I understand that if my account is turned over to Cornerstone Collection Services for non-payment, I will be charged an additional 35% to my balance turned over to Cornerstone.

X_____
Patient/Guardian Signature Date

Relationship to patient:_____