BLESSED
Acupuncture & Wellness Inc

INITIAL INTAKE & MEDICAL HISTORY

Date: ___ /___ /___

Name: _____ DOB: ___ / ___ / ___ Age: _____ Height: _____ Weight: _____

Address: _____ Unit/ Suite: ____ City: _____ Zip: _____

Phone: _____ Email: _____

Occupation: _____ Hours /week: _____

Health Insurance: _____ Subscriber ID #: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Copay: Visits:

Rate:

Have you ever tried Acupuncture, Cupping, or Chinese Herbal Medicine? _____

Main Complaint

Please identify your **CHIEF** Complaint:

1. _____
   _____

How **long** have you had this problem? _____ **Pain Level** (From 1 to 10 worst) : _____

Have you been given a medical diagnosis for these problems? If so, please list:

_____

What other treatments have you tried and what were the outcomes?

_____

Medical Concerns? (Common Age-Related Medical Conditions)

[ ] Cancer [ ] Weight [ ] Sexually Transmitted Disease [ ] Infertility [ ] Erectile Dysfunction

Others: _____

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ACUPUNCTURE INFORMED CONSENT TO TREAT

I 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 the acupuncturist named below 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 the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, 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 (Chinese massage), Chinese 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. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. 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 Chinese 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.

I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have 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.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ IN ITS ENTIRETY, UNDERSTAND, AND AGREE TO ALL THE TERMS AND CONDITIONS WRITTEN IN THE SECTIONS; *ACUPUNCTURE INFORMED CONSENT TO TREAT, PATIENT FINANCIAL RESPONSIBILITY STATEMENT, APPOINTMENT CANCELLATION POLICY AGREEMENT, RELEASE OF MEDICAL RECORDS AND INFORMATION, and ASSIGNMENT OF BENEFITS OF THIS INITIAL INTAKE & MEDICAL HISTORY APPLICATION .*

X _____ **X** _____ ____ **/** ____ **/** ____

PATIENT NAME (Print) **PATIENT SIGNATURE** **DATE**

X _____

PARENT SIGNATURE (Parent/Guardian Signature if under 18 years of age)

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PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing our practice for your healthcare needs. It is our goal to provide you with the highest quality healthcare services as possible. We ask that you please ***read and understand*** your financial responsibilities prior to receiving services.

1. I understand that I am responsible for knowing the policy provisions and rules of my insurance coverage(s) and that I am solely responsible for obtaining any necessary referrals prior to my appointment. Failure to obtain and present a valid referral may result in my being ***financially responsible*** for all services provided. Please note: a Doctor's Prescription is NOT a valid Referral.

2. I understand that I am ***financially responsible*** for any amount not covered by my insurance including, but not limited to, co-pays, co-insurances, deductibles and non-covered services.

3. I understand that if I *DO NOT* have valid medical insurance or Acupuncture coverage, I am ***financially responsible*** for all fees for provision of medical services and that, unless other arrangements have been made in advance, payment of these fees is expected in full at the time services are rendered.

4. I understand that failure to remit payment for any amounts deemed patient responsibility may result in my account being referred to collections or small claims and that I will be ***financially responsible*** for any additional fees incurred as a result.

5. I understand that any appointments missed, but not cancelled within twenty-four (24) hours, will result in my being charged a Missed / Cancellation Appointment Fee of **$40** per missed office visit.

6. I understand that I will be charged **$40** for any check returned by my bank for any reason.

APPOINTMENT CANCELLATION POLICY AGREEMENT

Blessed Acupuncture and Wellness is committed to providing exceptional care. Unfortunately, when a patient cancels without giving enough notice, they prevent another patient from being seen. It is the responsibility of the patient and a common courtesy to keep your scheduled appointments.

Please contact us via email at info@BlessedAcu.com or via phone (916) 827-1808 at least 24 hours prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please notify our office by 5:00 p.m. on Friday.

If prior notification is not given, I understand that I will be charged $40 for the missed / cancelled appointment. This amount is to be paid in full prior to scheduling the next appointment. If there are more than 3 missed / cancelled appointments, we reserve the right to deny service.

RELEASE OF MEDICAL RECORDS AND INFORMATION

I hereby authorize the release of any Protected Healthcare Information (PHI) to any involved insurance company, or their authorized third parties involved in my case unless I have specifically instructed otherwise.

ASSIGNMENT OF BENEFITS

I hereby authorize any insurance carrier, including Medicare, to make payment directly to Blessed Acupuncture and Wellness for any services rendered to me or my covered dependents of any amounts otherwise payable to me toward the reimbursement of any medical expenses incurred at this facility. I understand that I am ***financially responsible*** for payment of all services regardless of any payment issued by my insurance or not. A photocopy of this authorization shall be considered as effective and valid as the original. (Ver. 5/22)