SAN FRANCISCO
ACUPUNCTURE GROUP

Patient Contact Information

Name:_____**Nickname:**_____

Date of Birth:_____ **Age:**_____ **Weight:**_____

Address:_____

City:_____ **State:**_____ **Zip Code:**_____

Home phone:_____ **Work phone:**_____ **Cell phone:**_____

Email:_____

Referred by:_____

Family Physician:_____

Phone:_____

In Emergency Notify:

_____**Relationship:**_____

Phone: _____

Name: _____

Date of Birth: _____ Date:_____

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Welcome to San Francisco Acupuncture Group. Thank you for taking the time to fill out this questionnaire

Chief Complaint (When did the problem begin? Suddenly/gradually?)

Describe the quality (e.g., sharp, dull, hot/cold, numbness, etc.) and frequency of your complaint:

Other Complaint(s):

What makes your condition feel better?:

What makes your condition feel worse?:

How does this problem affect your daily activities?:

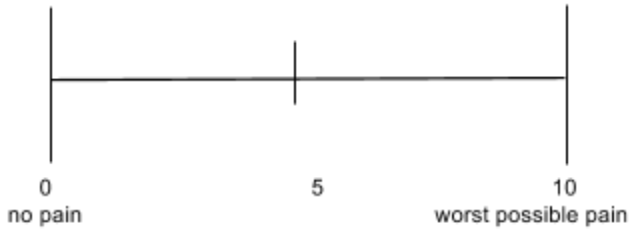
List the names of healthcare providers seen for this condition, include diagnoses and treatments given, and any changes to your condition:

Other relevant history related to your condition:

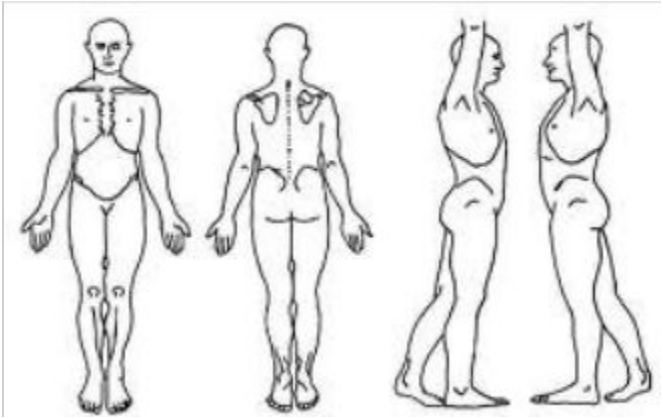
List all prescriptions/supplements :

Have you had acupuncture? When/what conditions? :

Rate your condition on the following scale (currently):



Mark painful / distressed areas with an "X" for pain ("Z" for numbness")



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Past Medical History (include dates of onset)

□Cancer □Diabetes □Hepatitis □HIV □Thyroid disease □High blood pressure

□Heart disease □Seizures □Food intolerances or allergies:_____

□Hospitalizations/surgeries/significant injuries (include dates): _____

_____

Other significant illness/medical history:

□Major scars (from accidents or surgeries):

Lifestyle

Exercise (include frequency/duration):

Sleep (hours per night):_____

Typical daily diet:

Do you / have you consumed any of the following. How much? How often? For how long (years)?

□Tobacco:_____ □Caffeine (type):_____

□Alcohol:_____ □Other substances (type):_____

Water intake per day (cups):_____

Treatments or health practices (psychotherapy, massage, yoga, etc.):

Occupation:_____

Occupational stress factors (physical, psychological, chemical):

Personal stress factors:

	Cancer	Diabetes	Heart Disease	High Blood Pressure	Anxiety/depression/mental illness
Mother					
Father					
Sibling					

Other:

General

□Night sweats □Insomnia □Disturbed sleep □Poor Balance □Anemia

□Localized weakness □Sweating easily □Tremors □Strong thirst

□Sudden energy drop (time of day):_____ □Weight change: __ gain __loss

□Easy bleeding/bruising □Low energy levels/Fatigue

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Head, Eyes, Ears, Nose, Throat

□Headaches (type/location/frequency):_____

□Sinus problems Pain: □facial □eyes □ears □jaw

□Corrective lenses □Problems with vision:_____ □Problems with hearing:_____

□Teeth problems □Teeth grinding □Thyroid problems □Recurrent sore throat

□Other head or neck problems:

Neurological

□Seizures □Dizziness □Poor coordination □Loss of balance □Concussion □Numbness

□Other neurological problems:

Cardiovascular

□Chest pain □High blood pressure □Low blood pressure □Swelling of hands or feet □Fainting

□Cold hands/feet □Rapid heartbeat □Palpitations/irregular heartbeat □Sensations of heat

□Other cardiovascular problems:

Respiratory

□Shortness of breath □Difficulty breathing □Wheezing □Cough □Phlegm □Bronchitis

□Asthma □Coughing blood □Pain with deep inhalation □Difficulty breathing when lying down

□Other respiratory

problems:_____

Digestive

□Indigestion □Bad breath □Belching □Gas □Bloating □Heartburn □Nausea

□Vomiting □Abdominal pain □Constipation □Laxative use □Diarrhea/loose stools

□Painful defecation □Black stools/blood in stools □Hemorrhoids □Food intolerance

□Excessive/lack of appetite □Food Cravings

□Other digestive problems:

Genitourinary

□Difficult or painful urination □Urgent urination □Decrease in flow □Frequent urination

□Do you wake up at night to urinate? □Blood in urine □Kidney stones □Inadequate erections

□Low sex drive

□Other genitourinary problems:

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Gynecologic

Age at first menses_____

Age at menopause_____

□Pregnant (mos.)_____ □Premenstrual changes □Heavy menstrual flow □Painful menses

□Irregular menses □Discharge

□Pregnancies (#)_____ □Miscarriage □Abortion □Abnormal vaginal bleeding or discharge

□Other gynecological problems:

Mental-Emotional

□Poor memory □Anxiety/Nervousness □Easily susceptible to stress □Frequent crying

□Depression □Mental restlessness □Bad temper/easily angered or agitated

□Difficulty making plans and decisions

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Other mental-emotional problems?

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SAN FRANCISCO ACUPUNCTURE GROUP

San Francisco Acupuncture Group Office Policies

Thank you for taking the time to read and understand these policies.

Appointments and Scheduling

- Treatments are by appointment only. Walk-ins are available, but please call.
- Please be on time for appointments.
- From time to time, unforeseen circumstance may arise that prevent you from arriving on time for your appointment. In fairness to others, our policy is to accommodate patients who are time. Late-comers will be seen at the first available opportunity. **If you are more than 15 minutes late, you may be asked to reschedule.** This enables us to stay on time.
- We know that your schedule may be busy, and that your time is valuable. We make every effort to respect your time and keep on schedule. Please notify us of appointment changes or cancellations at least 24 hours in advance of your scheduled appointment.

Changes or cancellations made within 24 hours
of scheduled appointments are subject to a full visit fee.

_____Initials

Fees / Insurance

- The fee for the initial evaluation/treatment is $225 subsequent visit fees vary based on procedures, insurance coverage, deductible, and co-pays.
- Payment (including deductible and copay) is due at the time of service unless prior arrangements are made. Invoices not paid within 60 days will be turned over to internal collections. Invoices not paid within 120 days are subject to patient dismissal, submission to a collections agency and notification to your insurance plan.
- Insurance policies vary in their coverage of acupuncture and related services. As a courtesy to our patients, we verify acupuncture benefits and file the appropriate insurance forms, but it is your responsibility to understand your health care coverage and exclusions, and to notify us of any changes to your medical coverage.
- **All payments for acupuncture claims received directly by the patient from their insurance company must be reimbursed to the acupuncture provider unless a prior written arrangement is made.**
- **While we make every effort to accurately verify policies, and to submit and pursue claims, we cannot guarantee insurance payments; if insurance does not cover the full cost of treatment, you are responsible for the balance due.**

I have read and agree to the above policies.

Signature **Date**

Name: _____

Date of Birth: _____ Date:_____

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Notice of Patient Privacy

Health Insurance Portability and Accountability Act (HIPAA)

SF Acupuncture Group is dedicated to preserving your personal health information. We are required by law to protect personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others your medical information for the purposes of providing or arranging health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The Effective Date at the top left hand side of this page indicates the date of the most current NOTICE in effect.

You have a right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask the front desk and we will provide you with a copy.

If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact SF Acupuncture Group at (415) 445 9388. You may also send a written complaint to the US Department of Health and Human Services.

Informed Consent to Treatment

I consent to acupuncture treatments and other procedures within the scope of the California State Acupuncture License by any provider I am treated by at SF Acupuncture Group. I have discussed the nature and purpose of my treatments with their practitioners.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, micro-current stimulation, light therapy, massage therapies, herbal and nutritional supplements, and nutritional counseling.

I have been informed that acupuncture is a safe method of treatment, but it may have 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 this clinic uses sterile, disposable, single use needles, and maintains a clean and safe environment. Burns and/or scarring are potential risk of moxibustion. I understand that while this document describes the major risks of treatment, other risks and side effects may occur.

The herbs and nutritional supplements (from plant, animal, or mineral sources) carried by this clinic are safe in normal dosages--some may be toxic in large doses. I understand that some supplements are contraindicated during pregnancy. Some possible side effects of taking herbal and nutritional supplements include nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling tongue.

I understand that the herbal and nutritional supplements must be taken according to specific instructions provided verbally and in writing by my acupuncturist. Some supplements may have an unpleasant smell or taste. I will immediately notify a provider of SF Acupuncture Group of any unanticipated or unpleasant effects associated with the consumption of herbal or nutritional supplements.

I will notify a provider of SF Acupuncture Group if I am or become pregnant.

I do not expect providers of SF Acupuncture Group to be able to anticipate and explain all the possible risks and complications of treatment, and I will rely on them to exercise judgment during the course of treatment, based on the facts then known, to determine the best response.

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

By voluntarily signing below, I agree that I have read, or have had read to me, this consent to treatment, have been informed about the possible risks of acupuncture and related 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.

_____

Print name of Patient (or representative)

_____

Signature of Patient (or representative) Date