ACUPUNCTURE CENTER

(310) 360-7556
2506 Overland Ave, Los Angeles, CA

Patient Registration

Name:_____ Date:_____
Email:_____
Home Phone:_____ Cell Phone:_____
Address:_____ City:_____ State:_____Zip:_____
Age:_____Date of Birth: ___/___/_____ Sex:_____ SSN:___-___-_____
Marital Status: Single Married Separated Divorced Widowed DL#:_____

Employer

Company Name:_____Occupation: _____Phone: _____
Address:_____City: _____ State:_____Zip: _____

Spouse Employer

Company Name:_____Occupation: _____Phone: _____
Address:_____City: _____ State:_____Zip: _____

Medical Information

Emergency Contact:_____Relationship:_____ Phone:_____
Family Physician:_____ Phone: _____
Known Medical Problems:_____
How did you hear about our office?_____

Office Policy

Payment: At the time of service payment is due unless prior written agreement has been made. There is a service charge of $35 for every returned check.

Outstanding Balance: In case of outstanding balance, a bill will be sent to the patient requesting payment due upon receipt. After 30 days, a 5% interest fee will be added to any unpaid balances. If the balance is not paid in a timely manner, we reserve the right to use a collection company that may report to all credit bureaus. All charges incurred due to collection procedures are the account holder's responsibility.

Herbs: A restocking fee of $2 per bottle/bag will be charged for unopened, non personalized herbal formulas. Personalized and opened herbal formulas MAY NOT be returned.

Cancellation/Missed appointment Policy: Cancellations or missed appointment without 24 hour notification (prior to appointment time) will result in a $50 charge. To avoid any inconvenience, please contact us at least 24 hours before your appointment time to change or cancel appointments.

I have read and agree to the terms of preceding paragraphs. All information present is true to the best of my knowledge.

Patient Signature:_____ Date:_____

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NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released to any person without your authorization.

Name _____ Date _____ Time _____ Account No. _____

Birth Date _____ Height _____ Weight _____

Major Complaints _____

_____

_____

_____

_____

Other Complaints _____

_____

Date of onset (when you first noticed your problem)? _____

Pain is: ❑ Minimal ❑ Slight ❑ Moderate ❑ Severe

How long have you had this condition? _____

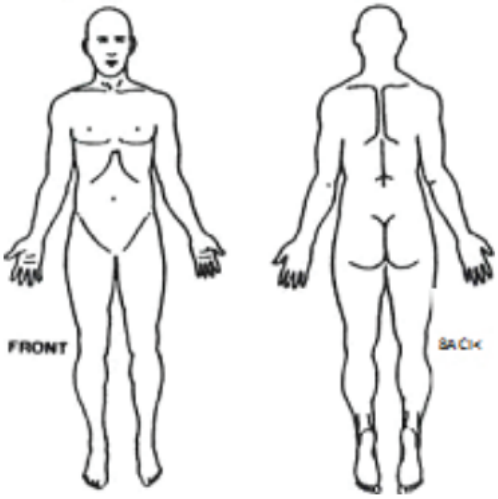
Have you had this in the past? ❑ Yes ❑ No When? _____

What makes it better? _____

What makes it worse? _____

Is your condition: ❑ Getting worse ❑ Constant ❑ Comes and Goes

PLEASE MARK YOUR AREAS OF PAIN



Medications/Drugs/Herbs you are currently taking _____

_____

List Surgeries/Operations you have had and dates _____

_____

Date of your last physical examination _____ By whom? _____

MEDICAL HISTORY: (Do you have or have you ever had): ❑ Arthritis ❑ Asthma ❑ Anemia ❑ Heart trouble ❑ Cancer
❑ Diabetes ❑ Epilepsy ❑ Stroke ❑ Kidney or bladder trouble ❑ Gallstones ❑ Ulcers ❑ High blood pressure
❑ Chronic fatigue ❑ Hepatitis ❑ Jaundice ❑ Sudden weight loss ❑ Sudden weight gain

Other _____

FAMILY HISTORY: (Has any member of your family had any of the above)? ❑ Yes ❑ No If yes, which member and what did they have?

_____

ENERGY LEVEL: ❑ High (Time of day) _____ ❑ Low (Time of day) _____

STRESS: ❑ None ❑ Moderate ❑ Severe What causes it? _____

SWEATING: ❑ Night sweats ❑ Rarely sweat ❑ Excess sweating _____

CIRCULATION: Feelings of ❑ Hot ❑ Cold What area? _____
❑ Bleed easily ❑ Cold limbs Other _____

SKIN: ❑ Dry ❑ Itchy ❑ Moist/clammy ❑ Burning ❑ Changing moles or lumps (cysts/tumors) ❑ Boils ❑ Frequent skin rashes
❑ Acne ❑ Hair loss/thinning ❑ Dry scalp ❑ Skin puffy/wrinkled ❑ Bruises easily (black and blue spots) ❑ Hives

Other _____

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SCARS: (List ALL scars from accidents or surgeries) _____

_____

SLEEP PROBLEMS: ❑ Trouble falling asleep ❑ Trouble staying asleep ❑ Restful ❑ Excess dreaming

Other _____ How many hours do you sleep a night? _____

HEAD: ❑ Headaches (what area?) ❑ Dizziness ❑ Memory loss ❑ Loss of balance Other _____

EYES: ❑ Eye pain ❑ Dry eyes ❑ Blurred vision ❑ Darkness under eyes Other _____

EARS: ❑ Poor hearing ❑ Earaches ❑ Ear discharge/infections ❑ Ringing/buzzing in ears Other _____

NOSE: ❑ Frequent nose bleeds ❑ Sinus trouble ❑ Frequent colds Other _____

THROAT: ❑ Sore throat ❑ Hoarseness ❑ Difficulty swallowing ❑ Jaw problems ❑ Teeth/gum problems ❑ Swollen tongue

Other _____

CHEST: ❑ Hard to breathe ❑ Wheezing ❑ Shortness of breath ❑ Mucus rattles when breathing ❑ Trouble breathing at night

❑ Pain/pressure in chest ❑ Palpitations ❑ Persistent cough ❑ Coughing blood ❑ Coughing phlegm

Sputum color _____ Consistency _____

Other _____

BLOOD PRESSURE: ❑ High ❑ Low ❑ Do not know

BOWELS: ❑ Diarrhea ❑ Constipation ❑ Bloody stools ❑ Black stools ❑ Mucus in stools ❑ Hemorrhoids

❑ Lower bowel gas ❑ Stools have foul odor ❑ Colon problems Number of bowel movements a day _____

Other _____

URINE: Color_____ Amount _____ Frequent urination ❑ Daytime ❑ At night

❑ Strong smelling urine ❑ Hard to urinate ❑ Pain or burning on urinating ❑ Blood in urine

❑ Frequent infections ❑ Water retention Other _____

MUSCULOSKELETAL: Pain in: ❑ Neck ❑ Shoulder ❑ Between shoulders ❑ Arms/hands ❑ Hip ❑ Knee ❑ Fingers ❑ Big toe

❑ Upper back ❑ Mid back ❑ Lower back ❑ Bones sore/painful ❑ Loss of grip Swollen knees/elbows ❑ Leg cramps at night

❑ Weakness in legs ❑ Weak ankles ❑ Stiff all over ❑ Tingling in feet ❑ Muscle spasm/cramps ❑ Loss of feeling in hands/feet

❑ Painful joints ❑ Bursitis Other _____

NEUROLOGICAL: ❑ Nervousness ❑ Depressed ❑ Easily angered ❑ Easily irritated ❑ Frequent crying ❑ Worry/Anxiety

❑ Mood swings ❑ Memory confusion ❑ Poor concentration ❑ Suicidal ❑ Tremors ❑ Numbness/tingling limbs

❑ Poor coordination ❑ Muscle weakness ❑ Feel weak and shaky ❑ Seizures ❑ Neuralgia (nerve pain) ❑ Shingles

Other _____

FEMALES: Pregnant? ❑ Yes ❑ No Last monthly period _____ Last PAP test _____

Form of birth control: ❑ None ❑ Pill Other _____

Age started menstrual cycle _____ Age stopped _____ ❑ Menstrual pain ❑ Low backache

❑ Irregular ❑ Clotting ❑ Heavy bleeding ❑ Light scanty bleeding Color _____

❑ Water retention ❑ Mood changes ❑ Miss periods ❑ Low or no sex drive ❑ Painful breasts ❑ Hot flashes

❑ Food cravings Other _____

Discharges: ❑ Yellow ❑ Thick ❑ White ❑ Odor ❑ Itching ❑ Liquid Other _____

No. Pregnancies _____ No. Deliveries _____ No. Miscarriages _____ No. Abortions _____ No. Cesareans _____

Operations: ❑ Cervix ❑ Uterus ❑ Ovaries Other _____

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MALES: ❑ Low sexual drive ❑ Lack of sexual drive ❑ Impotence ❑ Ejaculation causes pain ❑ Discharges
❑ Pain or burning while urinating ❑ Premature ejaculation ❑ Prostate trouble Other _____

APPETITE: ❑ Excessive appetite ❑ Poor appetite ❑ Appetite keeps changing ❑ Feel tired or weak if a meal is missed
❑ Excessive thirst ❑ Never thirsty Other _____

Specific food cravings? ❑ Yes ❑ No If yes, what? _____

Other _____

DIGESTION: ❑ Stomach gas ❑ Lower bowel gas ❑ Heartburn ❑ Burning/belching ❑ Stomach pain ❑ Stomach cramps ❑ Nausea
❑ Vomiting ❑ Bad breath ❑ Sores in mouth ❑ Weight gain ❑ Weight loss ❑ Bitter/sour taste in mouth ❑ Abdominal bloating

How long after eating? _____ Food allergies? ❑ yes ❑ No If yes, to what? _____

NUTRITION: List some of your favorite foods _____

_____

Do you: ❑ Skip breakfast ❑ Eat a snack ❑ Eat a hearty breakfast

How many meals a day do you eat? _____ When is your biggest meal? _____

Do you eat when you are worried or rushed? ❑ Yes ❑ No How often? _____

Do you plan your meals according to the "Four basic food groups"? ❑ Yes ❑ No

How many glasses of water do you drink a day? ❑ Filtered ❑ Bottled

Do you use: Alcohol? ❑ Yes ❑ No Amount per week _____ Type _____

Tobacco? ❑ Yes ❑ No Packs per day _____ How many years _____

DO YOU:

Eat raw fruits or vegetables at least twice a day? ❑ Yes ❑ No

Eat green or yellow vegetables at least twice a day? ❑ Yes ❑ No

Eat frequently between meals? ❑ Yes ❑ No

Chew your food thoroughly before swallowing it? ❑ Yes ❑ No

Drink juice, milk or other drinks instead of water when thirsty? ❑ Yes ❑ No

Eat meat or dairy products 2 or more times a day? ❑ Yes ❑ No

Eat the same foods almost every day? ❑ Yes ❑ No

Eat when you are not hungry? ❑ Yes ❑ No

Eat until you feel full? ❑ Yes ❑ No

Occasionally go on a "crash" diet? ❑ Yes ❑ No

Always add salt at the table? ❑ Yes ❑ No

Patient Name _____ _____

Patient's Signature _____

Date _____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

What is HIPAA and what are its benefits?

The Health Insurance Portability and Accountability Act (HIPAA) went into effect on July 1, 1997. It protects an insured person's insurability. If a person has been insured for the past 12 months, a new insurance company cannot refuse to cover the person and cannot impose pre-existing conditions or a waiting period before providing coverage.

Our office respects your right to privacy. Information regarding the reason you sought therapy with us is strictly confidential and is used to communicate with your doctor, case worker, and claims for payment from your insurer and the Dept. of Labor & Industrial Relations (for Workers' Comp. claims) or for pre-authorization. Should any other official party request information about you, we would need to see your signed authorization to release information.

If a claim is unpaid due to the unavailability of the requested information, then you will be responsible for payment to us.
Evaluation reports, treatment plans, copy of prescriptions for therapy and progress notes are generally mailed to the insurer (case worker) to carry out treatment and receive payment for services.
In settlement cases, your attorney can request copies of your file with a written authorization from you. The other party's attorney will generally subpoena your records. A **subpoena** is a legal demand with which we must comply.
All therapies are on an appointment basis.
If you have questions regarding other alternatives, we can give you general information. Your primary care physician will determine what program for you to follow.

Patient Rights Notice of Privacy Policy.

•A patient/client may request restrictions on certain uses and disclosures of the protected information.

• You have the right to receive confidential communication of protected health information.

• You have the right to inspect and request a copy of protected health information & medical records.

• You have the right to amend protected information (there is an appeals process).

• You have the right to an accounting of disclosures of protected health information.

We reserve the right to change our privacy policy in accordance with HIPAA, and would send such notice to your last known address if your case is involved.

I have read and understood my rights regarding privacy of information and under which conditions this information is shared with others so that I may receive a therapy and claims be made on my behalf (only for insurance purposes).

I hereby authorize Dr. Hua Bing Wen L.Ac. DAOM, to contact and communicate with the healthcare providers I have listed on the intake form for the purposes of care coordination, exchanging relevant health information, and ensuring the continuity and quality of my treatment. I also understand and agree that Dr. Hua-Bing Wen may reach out to these providers for general professional collaboration unrelated to my specific case, such as consultation, networking, or training, provided that my personal health information is not disclosed in those contexts. All communications will be conducted in accordance with applicable privacy laws and professional ethical standards. I acknowledge that I have received the "Patient's Rights" and I will__will not __ take a copy with me Initials_____

Print Name:_____Signature: _____ Date

A copy of your rights as our client/patient is available for you and clipped to this form. Please keep that copy. HIPAA Chart

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Informed Consent

Acupuncture is part of a larger medical system called Chinese Medicine that includes other therapeutic modalities. This medical system relies on your body's innate healing capacity and requires each person to take responsibility for their own health by participating in the healing process. In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is attained. Every patient participates with the acupuncturist in a healing partnership. The statements below describe some of the therapeutic modalities which may be employed during treatment, and assist in patient understanding and participation in the treatment process.

Acupuncture is a technique which uses small, sterile, stainless steel needles inserted at specific points in the body, causing a positive response in order to correct various ailments. Only disposable needles are used in this clinic. The location of application of the needles, as well as the depth of the needle inserted, is determined by the nature of the problem. I understand that the application of these needles may be accompanied by a brief painful sensation, and that there is a slight possibility of minor swelling, bleeding, discoloration of skin, hematoma, a bruise at the site needled, or fainting. Momentary euphoria or light-headedness may occur after acupuncture treatment. The attending acupuncturist can easily handle any immediately reported problems that arise from the acupuncture treatment, and the possibility of minor problems need not be a cause for concern.

Electrical stimulation of the acupuncture needles involves using a small, battery-powered stimulator attached by wires to the acupuncture needles. A slight throbbing or tingling sensation may be felt during and for a few hours after the use of this stimulator. This modality is usually employed for pain management and other specific conditions.

Moxibustion is the application of indirect heat supplies by burning the herb Folium Artimesiae Vulgaris (commonly known as mugwort) over a single acupuncture point or group of points. This generally reduces a pleasurable sensation of relaxation. The area being treated may remain red and warm for several hours after treatment. In rare incidents, a minor burn may occur at the site of moxibustion. The attending acupuncturist can readily address this.

Cupping uses round vacuum cups over a large muscular area, such as the back, to enhance blood circulation to the designated area. This method may produce a deep redness, discoloration, and on rare occasions, a minor blister may appear, which can persist for several days. These marks will resolve on their own and are not indications of complication or injury.

Qi Gong, Chinese for "energy work," is a non-invasive healing modality that predates the use of acupuncture needles, and incorporates the same therapeutic basis as acupuncture.

Herbal supplements are used to facilitate the body's own restorative process. These herbs are usually taken in tea form by boiling dried plants in their natural forms. Chinese herbal teas tend to taste bitter because they are made primarily from roots and barks. On rare occasions, temporary gastric upset may occur. If any discomfort persists, and is accompanied by hives or shortness of breath, contact our attending acupuncturist immediately.

I hereby certify that by signing this form that I have read and understand this form. Any point that I did not understand was explained to me by clinic personnel.

Patient's Signature _____ Date _____

Signature of Patient's Representative _____ Date _____