Patient Information Sheet

TRINITY ACUPUNCTURE, INC.
4305 Torrance Blvd. #208, Torrance, CA 90503
310.371.1777 | www.trinityacu.com

Important: Complete this form as thoroughly as possible. Some questions may seem unrelated to your condition, but they may affect your diagnosis and treatment. All information is confidential.

Date	Full Name			Email Address:	
Gender	Date of Birth	Age	SSN -- --	Marital Status S / M / D / W	
Address			City	State	Zip
Daytime Phone # (home, work, cell – circle one)			Alternate Phone # (home, work, cell – circle one)		
Emergency Contact & Relationship			Phone Number of Emergency Contact		
Circle Health Insurance Coverage None PPO HMO Workers' Comp Auto Injury with MedPay Other_____					
Primary Care Doctor			Specialty		
Other Doctors You See			Specialty		
How did you hear about our office (please circle one)? Google Yahoo Yelp Acufinder Referral (whom may we thank?): _____ Other					

Major Complaint(s), in order of importance to you and circle degree:

1. Severe Moderate Slight _____

2. Severe Moderate Slight _____

3. Severe Moderate Slight _____

Patient _____ Date _____

MEDICAL CONDITONS *Please list conditions & surgeries you have or have had and year diagnosed*

YEAR	CONDITION/SURGERY	ALLERGIES *Medications, Seasonal, Environmental, Food*	OCCUPATIONAL CONCERNS *Check (✓) if your work exposes you to the following*
			☐ Stress
			☐ Heavy Typing/Computer Use
			☐ Hazardous Substances
			☐ Heavy Lifting
			☐ Other

LIFESTYLE	
Alcohol	Never Rarely Occasionally Frequently
Smoking	Y / N
Recreational drugs	

FEMALE PATIENTS
- ❖ Last menstrual period __ / __ / _____
- ❖ Cycle length (e.g. 28 days) _____
- ❖ Period duration (e.g. 5 days) _____
- ❖ Labor/delivery (# of times) _____

MEDICATIONS *Please list all prescription medication you use. Include those which you may only use occasionally. Remember inhalers, eye drops, nose drops.*

PRESCRIPTION NAME	PURPOSE	HOW LONG	DOSE	HOW OFTEN	LAST DOSE

SYMPTOMS *Check (✓) for each symptom you currently have*

LIVER/GALLBLADDER
☐ Irritability
☐ Depression
☐ Headache/migraines
☐ Visual problems
☐ Red eyes
☐ Dry/itchy eyes
☐ Spots in front of eyes
☐ Blurred vision
☐ Feeling of lump in throat
☐ Clenching of teeth at night
☐ Muscle cramping
☐ Muscle twitching
☐ Joints feel tight/stiff
☐ Cold hands/feet
☐ Soft/brittle nails
☐ Craving/avoiding sour foods

KIDNEY/URINARY/BLADDER
☐ Urinary problems
☐ Frequent urination
☐ Incontinence
☐ Weakness/pain in lower back
☐ Aching bones
☐ Feel cold easily
☐ Low sexual energy
☐ Excess sexual desire
☐ Poor memory
☐ Loss of hair
☐ Hearing problems
☐ Ringing in ears
☐ Craving/avoiding salty food

HEART/SMALL INTESTINE
☐ Heart palpitations
☐ Chest pain
☐ Dizziness
☐ Insomnia
☐ Easily startled
☐ Restlessness/agitation
☐ Anxiety
☐ Breathlessness
☐ Vivid dreams
☐ Dreams are bothersome
☐ Lack of joy in life
☐ Laughing for no reason
☐ Craving/avoiding bitter foods

LUNG/LARGE INTESTINE
☐ Dry cough
☐ Cough with sputum
☐ Nasal discharge
☐ Poor sense of smell
☐ Nose bleeds
☐ Itchy, red or painful throat
☐ Dry mouth
☐ Skin rashes
☐ Itchy skin
☐ Grief, sadness
☐ Shortness of breath
☐ Allergies
☐ Low resistance to colds or flu
☐ Low physical stamina
☐ Mild fever comes and goes
☐ Craving/avoiding spicy foods

SPLEEN/STOMACH
☐ Heaviness anywhere in body
☐ Fatigue
☐ Hard to get up in the morning
☐ Edema (swelling)
☐ Muscles feel tired often
☐ Easy bruising and bleeding
☐ Bad breath
☐ Low appetite
☐ Snacking
☐ Tendency towards hypoglycemia
☐ Difficulty digesting oily foods
☐ Nausea
☐ Vomiting
☐ Gas/belching
☐ Bloating
☐ Hemorrhoids
☐ Constipation
☐ Diarrhea
☐ Abdominal pain
☐ Indigestion/heartburn
☐ Over-thinking
☐ Tendency to become obsessive
☐ Craving/avoiding sweets

INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

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 treats 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 now.

I understand that methods or 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 these 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. 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. Burns and/or scarring a potential risk of moxibustion and cupping. 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 and if I choose to take them, I do so at my own risk. Some possible side effects of taking herbs are nausea, gas, stomach ache, 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 are 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 for to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT SIGNATURE **X** Date (Indicate relationship if signing for patient)
(Or Patient Representative)

OFFICE SIGNATURE **X** Date

PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW YOUR HEALTHCARE INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Duties Regarding Your Healthcare Information

We are required by law to:

- Maintain the privacy of your healthcare information;
- Provide you with this notice of our legal duties and healthcare information privacy practices; and
- Abide by the terms of this notice.

Your Rights Regarding Your Healthcare Information

Right to Inspect and Obtain Copies:

You have a right to inspect and obtain copies of your healthcare information that we maintain. Usually this includes medical and billing records. You must make your request in writing and we may charge a standard fee for the costs of copying, mailing or other supplies associated with your request.
We may deny your request to inspect and obtain copies in certain limited circumstances. If you are denied access to your healthcare information, you will be notified in writing.

Right to Request Restrictions:

You have a right to request in writing a restriction on the healthcare information that we use or disclose for treatment, payment or healthcare operations. You also have the right to request in writing a limit on the healthcare information we disclose to someone who is involved in your care or the payment for your care, like a family member.
In your written request, you must tell us: the information you want to limit; whether you want to limit our use, disclosure or both; and to whom you want the limits to apply (for example, disclosures to your spouse). We are not required to agree to additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to Revoke Authorization:

If you give us an authorization, you may revoke it at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect.

Right to a Copy of This Notice:

You have the right to obtain a copy of this notice at any time

Uses and Disclosures of Healthcare Information Without Your Authorization

The following categories describe different ways that we may use and disclose your healthcare information without your written authorization.

Payment:

We may use and disclose your healthcare information to obtain payment for services we provide to you. We may disclose your healthcare information to another healthcare provider or entity subject to the federal Privacy Rules so they can obtain payment.

Healthcare Operations:

We may use and disclose your healthcare information in connection with our healthcare operations. Healthcare operations include:

- quality assessment and improvement activities;

- reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- business planning and development; and
- business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified medical information or a limited data set.

We may disclose your healthcare information to another entity that has a relationship with you and is subject to the federal Privacy Rules, for their healthcare operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, or detecting or preventing healthcare fraud and abuse.

On Your Authorization:

You may give us written authorization to use your healthcare information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your healthcare information for any reason except those described in this notice.

To Your Family and Friends:

We may disclose your healthcare information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.
Before we disclose your healthcare information to a person involved in your healthcare or payment for your healthcare, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your healthcare information based on our professional judgment of whether the disclosure would be in your best interest.
We will also use our professional judgment and our experience with common practice to allow a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of healthcare information.

Disaster Relief:

We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services:

We may use your healthcare information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your healthcare information to a business associate to assist us in these activities.

Patient Signature _____

Date: _____

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OFFICE POLICIES

We would like to thank you for choosing Trinity Acupuncture. Our goal is to provide and maintain a good practitioner-patient relationship. To achieve this, we would like to keep you informed of our current office and financial policies as outlined below. Your clear understanding of these policies is important to our professional relationship.

Financial Policies

We will verify your insurance benefits and bill out-of-network for services rendered at our office as a courtesy to you. However, it is ultimately your responsibility to understand your policy details and to pay for any balances owed. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co pays must be paid at the time of service. After your visit charges have been reconciled, any balance remaining on your account for services not covered by your insurance company is your responsibility. If you have no insurance coverage, your courtesy discounted rate will be due at the time of your visit. A $30 fee will be charged for any returned checks. A $25 late fee will be automatically added to your bill for every 30 days your payment is late. Any balance outstanding longer than 90 days will be forwarded to a collection agency. Please be sure to notify us of any changes in insurance, address or phone numbers. Please reach out to our front office with any questions or concerns.

Appointments

<u>Cancellation Policy</u>

In our desire to be effective and fair to all of our patients and out of consideration for our practitioners' time, we have adopted the following policies:

24 hour advance notice is required when canceling an appointment. This allows the patients on our waitlist to make an appointment for that time.

If you are unable to give us 24 hours advance notice (barring any extenuating emergencies) or miss your appointment without notice, **you will be charged a cancellation fee of $40.00.**

Late Arrival Policy

We try very hard to minimize your waiting time, and in order to do so we need to start and finish appointments on time. Depending upon how late you arrive, your practitioner will determine if there is enough time remaining to start a treatment, and regardless of the length of the treatment actually given, **you will be responsible for the "full" session.**

Out of respect and consideration to your practitioner and other patients, please plan accordingly and be on time.

WE LOOK FORWARD TO SERVING YOU

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ACKNOWLEDGEMENT OF ASSIGNMENT OF BENEFITS

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided the Notice of Privacy Practices which describes how my medical information may be used and disclosed, and how I can get access to this information.

Initials: _____

FINANCIAL & OFFICE POLICIES

I hereby acknowledge that I have read and I understand Trinity Acupuncture, Inc's financial and office policies and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Initials: _____

ASSIGNMENT OF BENEFITS

I hereby authorize all insurance benefits to be paid directly to Trinity Acupuncture, Inc. for services rendered. I understand that I am responsible for charges as designated by my insurance company (e.g. deductibles, coinsurance, and co-pays). I am also responsible for charges not covered by insurance including but not limited to charges for missed appointments or finance fees accrued on late balances. I authorize Trinity Acupuncture, Inc. to release information to my insurance company when requested.

Initials: _____

Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to Trinity Acupuncture, Inc.

_____ _____

Signature Date

_____

Printed Name