PLUM 李 FAMILEE ACUPUNCTURE
INTEGRATIVE HOLISTIC MEDICINE

A complete understanding of our patients is essential for successful health care and preventative medicine. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

PERSONAL INFORMATION

Name:					Today's Date:
First	*Middle Initial*	*Last*			
Address:					City:
State:	Zip:	Email Address:			
Date of Birth:		Age:	Weight:	Height:	Sex: □ Male □ Female
Phone No.:		Secondary Phone No.:			Occupation:
Emergency Contact Name:					Emergency No.:
Family Physician:					

Main problem you would like to address:

When did the problem begin?

Has anyone diagnosed your problem? If so, please specify.

Whom may we thank for referring you? Or how did you hear about us?

MEDICAL HISTORY

Significant Illnesses (Please include dates whenever possible):

□ Cancer:	□ Diabetes:	□ Heart Disease/High Blood Pressure:
□ Hepatitis:	□ Tuberculosis:	□ Thyroid Disease:
□ Seizures:	□ HIV/AIDs:	□ Other:

Surgeries/Hospitalizations:

Major Trauma (auto accidents, falls, etc.):

Allergies (drugs, chemicals, foods):

Medicines taken within the last 3 months (include over-the-counter drugs, vitamins, herbs, etc.):

Are you pregnant, or is there a possibility that you may be pregnant?

Are you on a restrictive diet? What kind?

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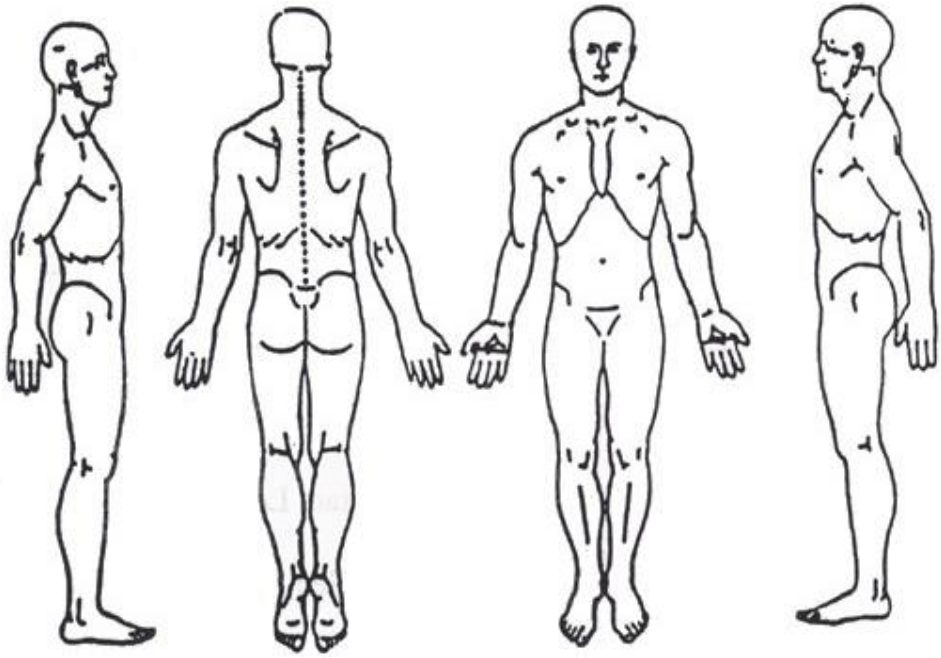
PATIENT PAIN CHART

Please circle areas to indicate where you are experiencing pain.



FAMILY HISTORY

Please indicate the affected family members:

□ Diabetes:	□ High Blood Pressure:	□ Heart Disease:
□ Stroke:	□ High Cholesterol:	□ Asthma:
□ Allergies:	□ Alcoholism:	□ Alzheimer's:
□ Parkinson's:	□ Seizures:	□ Gall Stones:
□ Kidney disease:	□ Cancer (include type):	
□ Other:		

Is there anything else you would like us to know?

PLUM 李 FAMILEE ACUPUNCTURE

HOLISTIC AND INTEGRATIVE ORIENTAL MEDICINE

INFORMED CONSENT TO ACUPUNCTURE/ORIENTAL MEDICINE TREATMENT

I hereby request and consent to Acupuncture/Oriental Medicine treatment(s) and other clinical procedure(s) provided to me (or to the patient listed below, for whom I am legally responsible) by the below named Licensed Acupuncturist and/or any other Licensed Acupuncturist who now or in the future may treat me while employed by, working or associated with, or serving as back-up for the treating Acupuncturist named below, including those working at this clinic or any other clinic.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, application of heat, Tui-Na, Chinese or Western herbal supplements, and informal nutritional and lifestyle counseling.

I have been informed that Acupuncture/Oriental Medicine treatments are generally safe, but some of the following side effects may occur:

- There may occasionally be bruising, numbness or tingling sensations on or near the needling sites that may last a few days.
- There have been very rare instances reported of fainting, infections, and scarring.
- There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax.
- Burns and/or scarring can be a potential risk of moxibustion.
- There may be bruising after cupping.

The herbal and nutritional supplements (which are from plant, animal, or mineral sources) that may be recommended are generally considered safe in the practice of Oriental Medicine, although some of them may have toxic effects in large doses. I have been informed that some of the possible side effects of taking herbal medicines may include nausea, vomiting, diarrhea, gas, stomachache, rashes/hives, and tingling sensation of the tongue. If I experience any of these reactions, I will promptly inform the treating Acupuncturist.

I understand that some herbal and nutritional supplements may be inappropriate during pregnancy. Thus, I will notify the treating Acupuncturist if I am or may be pregnant. I acknowledge that some of the herbal and nutritional supplements need to be prepared and consumed according to the instructions provided by the treating Acupuncturist.

I do not expect the treating Acupuncturist to be able to anticipate and explain to me all the potential risks and possible complications of the treatment(s) I receive, but I wish to rely on the clinic staff to exercise prudent judgment during the course of treatment which the treating Acupuncturist feels at that time, based on the facts then known, to be in my best interest.

I understand that the clinical and administrative staff may review my medical records and lab reports, but all my records will be kept confidential and will not be released to any party without my written consent.
By voluntarily signing this Informed Consent Form, I acknowledge that I have read, or have had read to me, this informed consent to treatment. I agree to the aforementioned procedures as deemed necessary by the treating Acupuncturist.

I understand that this Informed Consent agreement will cover the entire course of treatment for my present condition as well as for any future condition(s) for which I seek treatment.

_____ Date: _____

Signature of Patient (or Representative)

_____ _____

Print Name of Patient (or Representative) Relation to Patient (if applicable)

_____

Patient's Name (if different from the above signed)

PLUM 李 FAMILEE ACUPUNCTURE

HOLISTIC AND INTEGRATIVE ORIENTAL MEDICINE

FINANCIAL POLICY

Payment for all services rendered at Plum FamiLee Acupuncture is ultimately the patient's responsibility.

Insurance Patients:
We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, please be aware of the following:

- Your health insurance is a contract between you, the insurance company, and/or your employer. Plum FamiLee Acupuncture is not a party in that contract.
- Not all services are covered in all insurance contracts. Although your insurance may have general coverage guidelines, they are just estimates. At their discretion, the insurance company decides the amount of coverage on a case by case basis.
- You are responsible for your deductible, co-pay, and co-insurance amounts.

In the event that insurance coverage is denied, you will be billed the full amount for the services rendered.

Out-of-Pocket Patients (Uninsured Patients):
California State law allows health practitioners to grant discounts to uninsured or under-insured patients. We do grant this discount to those paying out of pocket. Fees for the initial visit are to be paid at that time. Subsequent fees are payable at the time of each visit unless other arrangements are made in advance with Plum FamiLee Acupuncture staff. Retroactive insurance billing is not permitted for patients who receive out of pocket discounts.

Automobile Accident/Personal Injury and Worker's Compensation Patients:
We may treat patients that were injured in an auto accident or on the job. If you wish to receive treatment from Plum FamiLee Acupuncture in such cases, we require you to submit an authorization letter from the insurance company prior to treatment.

Flexible/Health Spending Account:
Most Flexible/Health Spending Account (FSA/HSA) companies allow the use of your account to pay for Acupuncture services. If you wish to use your FSA/HSA to pay for services rendered at our office, we will gladly provide you with a detailed bill/receipt for your reimbursement.

Missed Appointments:
Your appointment time is reserved specifically for you. In the event of a missed appointment or an appointment cancelled within 24 hours of your scheduled time, a $60 charge will be assessed. Patients who miss multiple appointments will be only be permitted to book same-day appointments.

BY SIGNING BELOW, I UNDERSTAND AND AGREE THAT I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED AT PLUM FAMILEE ACUPUNCTURE.

_____ Date: _____

Signature of Patient (or Representative)

PLUM 李 FAMILEE ACUPUNCTURE
HOLISTIC AND INTEGRATIVE ORIENTAL MEDICINE

Notice of Privacy Practices

We treat your personal and medical information with the utmost privacy. This notice describes how your Protected Health Information (PHI) may be used or disclosed, and how you can access this information. Please review it carefully.

We are required by law to maintain the privacy and confidentiality of your Protected Health Information (PHI), and to provide our patients with the notice of our legal duties and privacy practices with respect to your PHI.

Disclosure of your Health Care Information

Treatment:	We may disclose your PHI to other healthcare professionals within our practice for the purpose of treatment, coordination of care, payment, and/or healthcare operations.
Payment:	We may disclose your PHI to your insurance provider for the purpose of payment or health care operations.
Workers Compensation:	We may disclose your PHI, as necessary to comply with State Workers' Compensation Laws.
Emergencies:	We may disclose your PHI to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or your death.
Public Health:	As required by law, we may disclose your PHI to public health officials of purposes related to: preventing or controlling disease, injury, or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
Judicial Proceedings:	We may disclose your PHI in the course of any judicial proceeding.
Law Enforcement:	We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness, or missing person, complying with a court order or subpoena, and other law enforcement purposes.
Deceased Persons:	We may disclose your PHI to coroners or medical examiners.
Public Safety:	It may be necessary to disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
Other Agencies:	We may disclose your PHI for military, national security, prisoner, and government benefits purposes.
Change of Ownership:	In the event that this Acupuncture practice is sold or merged with another organization, your PHI will become property of the new owner.

PLUM 李 FAMILEE ACUPUNCTURE
HOLISTIC AND INTEGRATIVE ORIENTAL MEDICINE

Patient Rights

- You have the right to request restrictions on certain uses and disclosures of your PHI. Please be advised, however, that Plum FamiLee Acupuncture is not required to agree to the restriction(s) that you request.
- You have the right to have your PHI received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have a right to examine and obtain a copy of your PHI.
- You have a right to request that this Acupuncture clinic amend your PHI. Please be advised, however that Plum FamiLee Acupuncture is not required to agree to amend your PHI. If your request to amend your information is denied, you will be provided with an explanation for the denial(s).
- You have a right to receive an accounting of disclosures of your PHI made by Plum FamiLee Acupuncture.
- You have the right to request a copy of this Notice of Privacy Practices at any time.

Changes of Privacy Practices:

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains.

Questions and complaints:

We are required by law to the privacy of your PHI, and to provide you with notice of our legal duties and privacy practices with respect to your PHI. If you have any questions or complaints about how your PHI has been managed, ask your treating Acupuncturist. If you are unsatisfied with the manner in which we handle your complaint, you may submit a formal complaint to the US Dept of Health & Human Services.

I have read the Notice of Privacy Practices and understand my right contained in this notice. By signing below, I authorize Plum FamiLee Acupuncture to use and disclose my PHI for purpose(s) of treatment, coordination of care, payment, and/or healthcare operations as described in this Notice of Privacy Practices.

_____ Date: _____
Signature of Patient (or Representative)

_____ _____
Print Name of Patient (or Representative) Relation to Patient (if applicable)

_____
Patient's Name (if different from the above signed)