Karen Chan Acupuncture & Herbal Medicine Inc.

187 40th St. Way, Oakland, CA 94611 510-384-9226
4220 H Street, Sacramento, CA 95819 916-891-2939
Fax: 866-281-7461

Personal Confidential Information

Date: ______________________

Name: ______________________ Date of Birth: __________ Gender: ________ Age: _____

Address: ______________________ City: ______________ State: _____ Zip: _____

Birth Place: ______________________________ Number of children: __________

Email: ____

Last 4 Digits of SSN #: __________________ Driver's License #: __________________

Occupation: ______________________ Employer: ___________________________

Work: ____________________ Cell: _______________ Home: _______________

Martial Status: ______ Spouse's Name: ____________________ Phone #: ___________

Emergency contact & Relationship: __________________________ Phone #: __________

Insurance Information

Insurance Company: ____

I.D. # ________________________ Group # __________________ Plan # ________

Insured's Name (if not you): __________________________ D.O.B. ______________

Relationship to Insured: ___________________ Insured's Employer: _______________

Name of Primary Care Physician: ___________________________ Phone: __________

Address: ____

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Main Complaint(s), in order of importance to you and date of onset:

1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________

Have you been treated for this condition before? Yes _____ No _______

If so, when and what means of treatment? ______________________________

____

____

List any surgeries you have had and the dates:

1. ______________________________ Date: __________
2. ______________________________ Date: __________
3. ______________________________ Date: __________

List any medications or OTC prescriptions you are taking.

1. ____
2. ____
3. ____
4. ____

Additional information you like to add.

____

____

____

____

Patient Name ______________________________ Date ____________________

Please mark **X** for present condition and **P** for past condition

Liver / Gallbladder

__ Irritability
__ Anger / frustration
__ Argumentative / Aggressive
__ Depression
__ Headaches / migraines
__ Red eyes
__ Dry / Itchy eyes
__ Spots in front of eyes
__ Blurred vision
__ Night blindness
__ Sensitive to sunlight
__ Feeling of lump in throat
__ Clenching of teeth at night
__ Muscle cramping / twitching
__ Joints feel tight / stiff
__ Abdominal pain / rib pain
__ Mood swing
__ Easily stressed
__ Nervous
__Cold hands / feet
__ Soft / brittle nails
__ Bitter taste in mouth (all day)
__ Difficulty making decision
__ Craving / avoiding sour foods

Kidney / Urinary Bladder

__ Frequent urination
__ Burning / painful urination
__ Incontinence
__ Incomplete urination
__ Genital discharge
__ Recurrent bladder infection
__ Weakness/Pain in lower back
__ Aching bones
__ Feel cold easily
__ Low sexual energy
__ Excess sexual desire
__ Short term memory
__ Loss of hair
__Hearing problems
__ Ringing in ears
__ Ear aches, infection
__ Craving/avoiding salty food

Heart / Small Intestine

__ Heart palpitations
__ Chest pain
__ Dizziness
__ Insomnia
__ Poor memory
__ Easily startled
__ Easily sweat
__ Restlessness / agitation
__ Impulsive
__ Anxiety
__ Shortness of breath on exertion
__ Vivid dreams
__ Nightmares
__ Lack of joy in life
__ Laughing for no reason
__ Bitter taste in mouth(am)
__ Craving/ avoiding bitter foods

Lung / Large Intestine

__ Dry cough
__ Cough with sputum
__ Sinus problem
__ Poor sense of smell
__ Chronic cough
__ Dry mouth
__ Skin rashes
__ Itchy skin
__ Hives
__ worry
__ Grief, sadness
__ Shortness of Breath
__ Spontaneous sweating
__ Allergies
__ Sore throat
__ Hoarse voice
__ Frequent colds
__ Low physical stamina
__ Craving/avoiding spicy foods

Spleen / Stomach

__ Heaviness anywhere in body
__ Fatigue all the time
__ Hard to get up in the morning
__ Afternoon fatigue(after lunch)
__ Edema (swelling)
__ Muscles feel tired often
__ Easy bruising and bleeding
__ Acne
__ Bad Breath
__ Undigested food in stool
__ Low / excessive appetite
__ Frequently snacking
__ Tendency towards hypoglycemia
__ Difficulty digesting oily foods
__ Chemical sensitivities
__ Nausea
__ Vomiting
__ Gas / belching
__ Hiccup
__ Bloating
__ Hemorrhoids
__ Constipation / Diarrhea
__ Indigestion / heartburn
__ Ulcers
__ Abdominal pain
__ Over-thinking
__ Poor memory
__ Tendency to become obsessive
__ Bleeding or painful gum
__ Difficulty swallowing
__ Sticky stool
__ Mucous stool

Bowel Movements:
Frequency ____________
Color ________________
Odor ________________
__ Craving / avoid sweets

Is there a family history of:
__ Cancer __ T.B. __ Diabetes __ Arthritis __ High blood pressure _Mental illness
__ Asthma __ Allergies __ Other, please list: ____

Please check all that apply to you:
__ Allergies __ Anemia __ High blood pressure __ Heart trouble __ Hepatitis __ HIV/AIDS
Other, please list: ____

Male

__ Low or no sex drive	__ Painful testicles
__ Excess sexual desire	__ Seminal emission
__ Impotence	__ Weak urine stream
__ Infertility	__ Dribbling urination
__ Hernia	__ Urethra discharge
__ Prostate problem	

Female

Age started menstrual cycle ___	Length of cycle ____	__ Lump in breasts/painful breast
Age stopped ____	Intervals between cycle ____	__ Ovarian cysts
Date of last cycle ____	Date last period began ____	__ Uterine cysts or tumors
Date of last PAP test ____	Quality of flow:	__ Excessive vaginal discharge
# of Pregnancies ____	___ Dark ___ Clots ___ Bright	__ Vaginal soreness
# of Caesareans ____	__ Excessive __ Irregular cycle	__ Vaginal itch
# of Miscarriage ____	__ Light scanty bleeding	__ Vaginal odor
# of Abortion ____	__ Missed period	Vaginal discharge color: ____
Age at menopause ____	__ Cramps	____
__ Hot flashes	__ Low backache	Other: ____
__ Vaginal dryness	__ Mood changes	____
	__ Water retention	

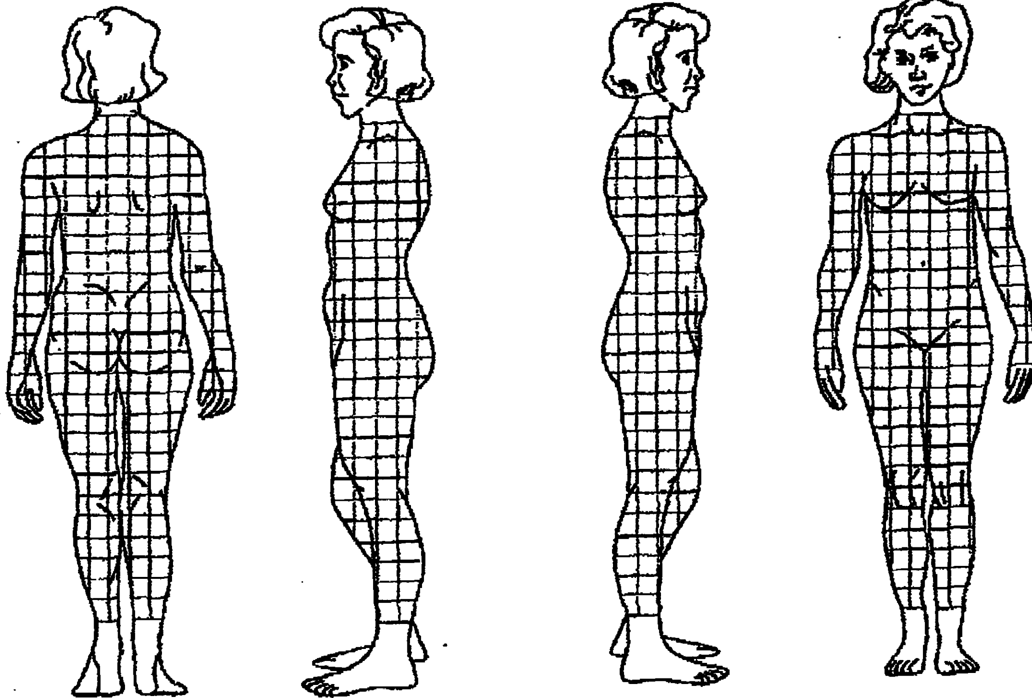
General

Weight ____	Occupational Hazards: ____
Height ____	Use sleeping pills Yes No __ Quantity/night
BP ____	__ Work with chemicals
Appetite: Low Moderate High	__ Work involves sitting a lot
Thirst for Water: Yes No __ Glasses/Day	__ Physical work
Coffee: Yes No __ Cups/Day	__ Driving a lot
Soda: Yes No __ Cups/Day	__ Exercise regularly
Artificial Sweeteners: Yes No	__ Get enough sleep
Cravings for Sugar: Yes No	__ Eat regular meals
Cravings for Salty Foods: Yes No	Stress level: Mild Moderate High
Alcohol: Yes No __ Glasses/Day	__ Prefer cold drinks
Smoking: Yes No __ Cigarettes/Day	__ Prefer hot drinks
Marijuana: Yes No __ Times/Day	__ Often feel cold
Other Drugs: ____	__ Often feel hot
	__ Comfortable

Musculoskeletal

__ Muscle pain	__ Neck pain / stiff neck	__ Loss of grip
__ Muscle cramps / spasm	__ Shoulder pain	__ Hand or finger pain
__ Painful/Swollen joints	__ Upper back pain	__ Wrist pain
__ Aches	__ Mid back pain	__ Elbow pain
__ Hip tightness	__ Lower back pain	__ Hand pain
__ Cold pain	__ Hip pain	__ Ankle pain
__ Poor circulation	__ Sciatica pain	__ Foot pain
__ Weak limbs	__ Numbness/tingling in limbs	__ Hernia disc
__ Arthritis	__ Burning sensation	__ Scoliosis
__ Stiffness/ Limited range of motion	__ Swollen joints	
	__ Bursitis	

Please mark your areas of pain:



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Payment Policy

We welcome you to our clinic. The following is our payment policy to assist you during your acupuncture health treatment. The range of price is base on severity and time spent on each individual's need. Please initial and sign the Payment Policy before being treated.

PAYMENT METHOD AND FEES

Payment (or co-payment in the case of patients with insurance) is due at the time of service. We accept cash, personal checks, VISA/MASTER/AMERICAN EXPRESS, debit card and HSA card. A super bill (receipt) will be provided to you to submit to your insurance company if needed.

Insurance Accepted

Cash Discount:
Initial Visit: $125 - $145   Follow-up Visit: $85

CANCELLATIONS FEES

- Appointment cancellations must be made at least 48 hours in advance to avoid a $45 cancellation fee.
- "No Show" is billed the entire charge of the treatment of $85.

INSURANCE AND PERSONAL INJURY CASES

For **personal insurance** Karen Chan, L.Ac. will give you a super bill with your diagnosis to submit to your insurance. I understand that regardless of my insurance status, I am ultimately responsible for any charges for professional services rendered by Karen Chan Acupuncture & Herbal Medicine Inc.

For our patients with health insurance, we will bill your health insurance company. Per state and federal law, under the False Claims Act and the Anti-Kickback Statute, patients with health insurance will be responsible for all co-pays, deductibles and non-paid fees deemed "patient responsibility" under their insurance plan(s). Patients paying cash will be provided a discount from insurance rates.

For **injuries due to accident (MVA)**, Karen Chan L.Ac. will charge upfront for acupuncture visits and a superbill will be provided to me to submit to my insurance company for reimbursement.

For **workers' compensation** claims Karen Chan, L.Ac. may bill my workers' compensation insurance carrier. I am responsible for payment only if I failed to cancel or keep my appointment.

I hereby authorize payment of medical benefits to Karen Chan, L.Ac. and the release of medical information necessary to process the claim. I read and understand and agree to this office financial policy.

Signed ______________________________ **Dated** ____________________

Informed Consent For Acupuncture Treatment And Care

I hereby request and consent to the performance of acupuncture treatments and other Oriental Medicine procedures including various modes of physio-therapy on me (or on the patient named below, for whom I am legally responsible) by the below named licensed acupuncturist and/or other licensed acupuncturist who now or in the future treat me while employed, working or associated with or serving as a back-up for the treating acupuncturist named below, including those working at this office/clinic or any other office or clinic.

I understand that methods or treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese or Western herbal medicine, and nutritional counseling. Sometimes blisters can occur with moxibustion.

I understand sterile disposable needles will be used and may be placed in the external ear and/or body points.

I have had the opportunity to discuss with the acupuncturist named below and/or with other office or clinic personnel the nature and purpose of acupuncture treatments and other procedures.

Acupuncture has the effect to normalize physiological functions, to modify the perception of pain, and to treat certain disease of dysfunctions of the body. I have been informed that acupuncture is a safe method of treatment, but occasionally there may be some bruising or tingling near the needling sites that last a few days. There have been very rare instances reported of fainting, slight bleeding, temporary discomfort, infections, scarring and hematoma at site of needle. There have been extremely rare instances reported of spontaneous miscarriage and pneumothorax. There may be some bruising after cupping.

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. I understand that some herbs may be inappropriate during pregnancy. If I experience any gastro-intestinal upset or allergic reactions to the herbs I will inform the acupuncturist.

I do not expect the acupuncturist to be able to anticipate and explain all risk and complications, and I wish to reply on the acupuncturist to exercise judgment during the course of the procedure which the acupuncturist feels at the time, based upon the facts then known in my best interests.

I understand 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 without my written consent.

I have read the above consent. I have also had an opportunity to ask questions about its content and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Patient's Signature: (parent if minor or guardian) ______________________________ Date Signed: ____________

Print Name: ______________________________ Relationship to Patient: ______________________________

ARE YOU PREGNANT? YES NO DO YOU HAVE A PACEMAKER? YES NO

Name of treating acupuncturist(s):________Karen Chan, L.Ac.______________________________

Consent For Purpose Of Treatment, Payment And Healthcare Operation

I consent to the use or disclosure of my protected health information by the Acupuncture and Herbal Medicine Clinic for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Acupuncture and Herbal Medicine Clinic. I understand that diagnosis or treatment of me at the Acupuncture and Herbal Medicine Clinic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Acupuncture and Herbal Medicine Clinic is not required to agree to the restrictions that I may request. However, if the Acupuncture and Herbal Medicine clinic agrees to a restriction that I request, the restriction is binding on the Acupuncture and Herbal medicine Clinic.

I have the right to revoke this consent, in writing, at any time, except to the extent that the Acupuncture and Herbal Medicine Clinic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Acupuncture and Herbal Medicine Clinic's Notice of Privacy Practices prior to signing this document. The Acupuncture and Herbal Medicine Clinic's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my Acupuncture and Herbal Medicine Clinic. This Notice of Privacy Practices also describes my rights and the Acupuncture and Herbal Medicine Clinic's duties with respect to my protected health information.

The Acupuncture and Herbal Medicine Clinic reserves the right to change the privacy practices that are described in the Notice of Privacy Practice. I may obtain a revised notice of privacy practices to the Acupuncture and Herbal Medicine clinic to be provided to me at any time.

____ ____________________

Signature of Patient or Personal Representative Date

____

Print Name of Patient or Personal Representative