ProAction Acupuncture

PATIENT REGISTRATION FORM

Name ____ Date of Birth ____________________

Address____________________________________ City _________________State ___ Zip _______

Phone Number __________________________ E-mail address: _______________________________

Emergency Contact Name: _____________________________Number: _________________________

Occupation:______________________________ Employer:___________________________________

What is your primary language?_______________________ Do you need language assistance? Y / N

How did you hear about us? ____

Have you had acupuncture before? ____

What health concerns would you like to address? ____

____

What treatments have you already received? ____

Are there other doctors/practitioners involved in your care? __________________________________

(Please include names, addresses, and phone numbers) ______________________________________

____

Are you currently pregnant? _______If yes, expected date of delivery: __________________________

Have you been diagnosed with any major medical conditions? ________________________________

____

Do you have a history of anxiety/depression or any other mental condition? _____________________

____

Have you ever been diagnosed with HIV/AIDS/Hepatitis or any other blood born disease? Y / N

When was the last time you went to your Doctor? ____

Height: _________ Weight: __________ Blood Pressure: _________/_________ When? __________

Do you have any other questions for the acupuncturist? ______________________________________

____

____

____

Signature Printed Name Date

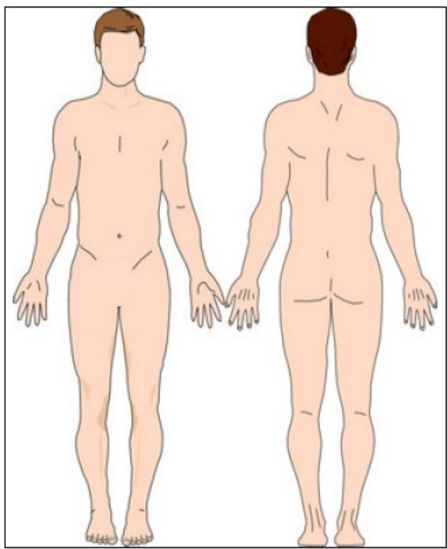
FAMILY HEALTH HISTORY:

Family History:	Father	Mother	Brothers	Sisters	Spouse	Children
Check those applicable						
Health (G:good, P: poor)						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Mental Illness						
Asthma/Hay fever/hives						
Kidney Disease						
Age (at death)						
Cause of death						

HEALTH HABITS:
Check yes or no and indicate how much and how often you use each of the following items. Circle Day or Week and indicate type

	Yes	No				
Tobacco smoking	[ ]	[ ]	____	Packs per day	Type	________________
Coffee	[ ]	[ ]	____	Cups per day/week	Type	________________
Tea	[ ]	[ ]	____	Cups per day/week	Type	________________
Alcohol	[ ]	[ ]	____	Drinks per day/week	Type	________________
Recreational Drugs	[ ]	[ ]	____	Times per day/week	Type	________________
Soft Drinks	[ ]	[ ]	____	Drinks per day/week	Type	________________
Artificial Sweetener	[ ]	[ ]	____	Packs per day/week	Type	________________

On the diagrams to the right, please indicate the areas in which you experience discomfort. If the discomfort radiates, please draw arrows



____

Signature Printed Name Date

Medication List

Please list all medications you are currently taking, including prescriptions, over-the-counter medications and herbal or vitamin supplements.

Allergies: (Please include any medicinal or food allergies you have.)

____

____

I am not taking any supplements or medications at this time (Please initial) ________________

Medication:	Start Date:	Herbs & Supplements:	Start Date:
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Signature Printed Name Date

ProActive Acupuncture

INFORMED CONSENT TO ACUPUNCTURE AND TREATMENT

I hereby request and consent to the performance of acupuncture and other procedures within the scope of practice of acupuncture and oriental medicine on me (or the patient named below for whom I am legally responsible) by that the acupuncturist named below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as backup for the acupuncturist named below, including those working at the office listed below, or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the acupuncturist named below and/or with other office personnel the nature and purpose of acupuncture

I understand and am informed that in the practice of acupuncture, there are some risks to treatment, including but not limited to nausea, local bruising and swelling, minor bleeding and dizziness. I do not expect the acupuncturist to anticipate and explain all the potential risks and complications. I will rely on the acupuncturist to exercise judgment during the course of the procedure based upon the facts then known, which are in my best interest.

I have read, or have had read to me, 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 futures condition(s) for which I seek treatment.

To be completed by the Patient:

____

Print Patient's Name

____

Signature of Patient

____

Witness to Patient's Signature

____

Translated by

____

Date Signed

To be completed by Patient's Representative, if necessary (e.g. if the patient is a minor or is physically or legally incapacitated):

____

Print Patient's Name

____

Print Name of Patient's Representative

____

Signature of Patient's Representative

____

Relationship or Authority of Patient's Representative

____

Date Signed

~Do Not Write Below This Line~

Name(s) of Acupuncturist(s) treating this patient:

____

Bradley Cimino L.Ac.

____

Lila Bigelsen L.Ac.

____

Golden Yung L.Ac.

Financial Policy

We accept medical insurance, workers compensation, auto injury, and cash paying patients

Fees and Services

Initial Visit (Includes consultation, exam, and acupuncture treatment)	$125
Return Visit	$75
Pre-payment plan (10 visits)	$600

- Patients are responsible at the time services are rendered
- We accept Cash, Check, Debit/Credit Cards, Health Savings Account (HSA)

Medical Insurance

(Medical insurances only cover treatment for pain related conditions)

We accept all medical insurances that offer acupuncture coverage. Patients utilizing their medical insurance must provide our office with the required information necessary to verify their coverage prior to treatments rendered. Co-Payment responsibilities are paid at the time of service. Patients are retro billed for deductible and co-insurance responsibilities after claims have been processed through their insurance.

Workers Compensation or Auto/Personal Injury

Patients seeking acupuncture for work related injuries must first be referred by their doctor and receive authorization for treatment from their insurance adjustor.

Patients seeking acupuncture for auto/personal injury must notify our office and complete additional paperwork for both patients utilizing Med Pay or a Lien.

24 - Hour cancelation Policy

When you schedule an appointment, professional time is set aside to provide for your care. A 24-hour notice is required if you cannot make your appointment. If you miss an appointment without giving the required notification, a $50 fee will be charged.

Please indicate your understanding and acceptance of these policies by signing below.

____

Signature Printed Name Date