

Wendy Stedeford Acupuncture  
Patient Information Form

RESPONSIBILITY FOR PAYMENT

As a courtesy to you, and if it is pertinent to your situation, we will gladly submit your charges to the appropriate parties. I- However, all services rendered by this office are charged directly to you. Ultimately, you are personally responsible for payment of these charges regardless of any insurance reimbursement or settlement you may or may not receive.

Returned checks will result in a \$40.00 charge.

IMPORTANT PLEASE READ

We always strive for excellence when it comes to patients' needs including being aware that your time, as well as ours, is precious. Please make every effort to arrive on time and we will make every effort to make sure you are seen promptly. If for some reason your appointment is pushed back, please understand that it could be because another patient is in dire need. And if that isn't the reason, then we apologize beforehand!

Also, please understand that every individual is unique in their anatomy. Occasionally, because acupuncture does use needles, you may experience slight bruising. This is a temporary result and will not adversely affect the benefits you receive from your treatment. If a needle causes you discomfort while it is being inserted, let your practitioner know and they can adjust the needle for you.

It's also very important to have eaten something within 4 hours of treatment or to let your practitioner know if you have any fainting tendencies because of the very rare chance of needle shock.

Private Policy Notice Acknowledgement of Receipt

I acknowledge that I have received a copy of Wendy Stedeford Acupuncture's Notice of Privacy Practices and I understand it contains information about the use and disclosure of my medical information.

By way of my signature, I provide Wendy Stedeford Acupuncture with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

\* It is the practice of this office to have patients wait in a common waiting room before being called by first name back to the treatment room. This office also reserves the right to use a sign in sheet which will be in plain view at the front desk.

Please sign below to acknowledge that you understand and agree to the slight risk involved in receiving treatment with acupuncture needles, that you understand, agree and have received a copy of the Private Policy Notice and that you understand and agree to our late and no show policy. **Welcome to the practice! If you have any questions today or at any time we will be happy to answer them and look forward to an enriching exchange with you!**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Wendy Stedeford Acupuncture Patient Information Form

Your date of birth: \_\_\_\_\_

How did you hear about us? (Please circle):

Newspaper   Advertisement   Published story   Phone book   Mailer/flyer   Website   Event

Medical referral   Friend/family   Other \_\_\_\_\_

Would you like to receive our monthly newsletter?

Give us your email address: \_\_\_\_\_

Emergency contact information:

Name and relationship to patient: \_\_\_\_\_

Their phone number and an alternative way to reach the contact: \_\_\_\_\_

What are your goals today? \_\_\_\_\_

Please tell us any allergies you might or do have:

\_\_\_\_\_

Please list any vitamins or supplements you are currently taking:

1.

2.

3.

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Primary Language \_\_\_\_\_ Sex M / F  
Last First  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Primary Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Other Phone \_\_\_\_\_  
Subscriber Name \_\_\_\_\_ Subscriber ID # \_\_\_\_\_ Group # \_\_\_\_\_  
Primary Health Plan \_\_\_\_\_ Patient/Member ID # \_\_\_\_\_  
2<sup>nd</sup> Health Plan \_\_\_\_\_ Primary Care Physician (PCP) \_\_\_\_\_ PCP Phone # \_\_\_\_\_  
(Required) (Required)

Are you under the care of a physician?  No  Yes, for what conditions? \_\_\_\_\_

Please describe your current health problem(s) \_\_\_\_\_

How and When it began \_\_\_\_\_ Is this work related? Y / N

What treatment have you received for the above condition(s)?  Surgery  Medications  Physical Therapy

Injections  Chiropractic  Massage  Other \_\_\_\_\_

Please describe your progress:  Worse  No Change  25% Better  50% Better  75% Better or \_\_\_\_\_

**Circle your current pain areas:** Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other \_\_\_\_\_

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Unbearable Pain**

In the past week, how much has your pain interfered with your daily activities?

**No Interference** 0 1 2 3 4 5 6 7 8 9 10 **Unable to carry on any activities**

How often are your symptoms present?  Constantly  Frequently  Intermittently  Occasionally

Describe your current health condition:  Excellent  Very Good  Good  Fair  Poor

**Please check all of the following that apply to you and list any medication(s) you are taking:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Dependence            | <input type="checkbox"/> Frequent Urination                            | <input type="checkbox"/> Stroke  |
| <input type="checkbox"/> Abnormal Menstruation              | <input type="checkbox"/> Headache                                      | <input type="checkbox"/> Tobacco Use - Type _____  |
| <input type="checkbox"/> Allergies                          | <input type="checkbox"/> Heart Attack                                  | Frequency _____/Day  |
| <input type="checkbox"/> Angina                             | <input type="checkbox"/> Heartburn or Indigestion                      | <input type="checkbox"/> Thyroid Disease   |
| <input type="checkbox"/> Arthritis/<br>Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure                           | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Artificial Joints                  | <input type="checkbox"/> Hospitalizations/Surgical<br>Procedures _____ | <input type="checkbox"/> Medications _____   |
| <input type="checkbox"/> Asthma                             | _____  | _____  |
| <input type="checkbox"/> Blood Disorder                     | <input type="checkbox"/> Kidney Disease                                | If a family member has had any of the following, please mark the appropriate box and explain the relationship: |
| <input type="checkbox"/> Breast Lumps                       | <input type="checkbox"/> Liver Problems                                |  |
| <input type="checkbox"/> Cancer/Tumor                       | <input type="checkbox"/> Osteoporosis                                  |  |
| <input type="checkbox"/> Convulsions/Seizures               | <input type="checkbox"/> Pacemaker                                     |  |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Palpitation/Arrhythmia                        |  |
| <input type="checkbox"/> Diarrhea/Constipation              | <input type="checkbox"/> Peptic Ulcer                                  |  |
| <input type="checkbox"/> Excessive Thirst                   | <input type="checkbox"/> Pregnant, # Weeks _____                       |  |
| <input type="checkbox"/> Fainting or Dizziness              | <input type="checkbox"/> Prostate Problems                             |  |
| <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Weight Gain/Loss                              |  |
| <input type="checkbox"/> Fever                              | <input type="checkbox"/> Sinusitis                                     |  |
|   |  |  |

**Comments** \_\_\_\_\_

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

**INFORMED CONSENT:**

\_\_\_\_\_  
Acupuncture Provider

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Contracted Provider named above and/or other ASH Contracted Provider who may treat me. I understand that the ASH Contracted Provider will explain all known risks and complications, and I wish to rely on the ASH Contracted Provider to exercise judgment during the course of the procedure, which the ASH Contracted Provider determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Contracted Provider has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Contracted Provider's use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy.
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH does not allow *direct* moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Contracted Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Contracted Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Contracted Provider. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

**Authorization for Release of Medical Information:** I further understand that my ASH Contracted Provider or an ASH acupuncture clinical services manager may need to contact my medical physician when the ASH Contracted Provider or an ASH acupuncture clinical services manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH to contact my medical physician if/when necessary.

**Treatment of Pediatric Patients <3 Years.** I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH to contact my child's medical doctor if/when necessary.

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Patient ID Number

\_\_\_\_\_  
Primary Care Physician (or specialist) Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Primary Care Physician (or specialist) Telephone

\_\_\_\_\_  
Date