Welcome to WELLSTREAM ACUPUNCTURE

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(323) 463-9355 wellstreamacupuncture@gmail.com

Confidential New Patient Information

Name _____ Date _____
Hm #_____ Wk # _____ Cel # _____
Email _____ *(please circle preferred contact method)*
Address _____
City _____ State _____ Zip _____

Date of Birth _____ Birth Place _____
Age _____ Gender: M / F Ht _____ Wt _____ Marital Status _____
Occupation _____ Employer _____

Emergency Contact _____ Hm # _____
Relationship to Patient _____ Cel # _____

How did you hear about our clinic? _____
Whom may we thank for your referral? _____

Primary Physician _____ Ph # _____Fax #_____
Address _____
City _____ State _____ Zip_____
Doctors Diagnosis _____
Date of ***last*** physical exam: _____ Date of ***next*** physical exam: _____

Will we be billing insurance? If yes, please provide the following:
Name of Primary Insurance Company _____
Name of Responsible Party/Spouse _____
Social Security # of Insured _____Birth Date of Insured _____
Policy ID# _____ Group # _____

Name of Secondary Insurance Company _____
Name of Responsible Party/Spouse _____
Social Security # of Insured _____Birth Date of Insured _____
Policy ID# _____ Group # _____

WELLSTREAM ACUPUNCTURE
COMPREHENSIVE NEW PATIENT QUESTIONNAIRE

NOTE: This is a confidential record of your medical history and will be kept in this office.
Information contained herein will not be released pursuant to HIPAA regulations.

Name _____ Date _____
Primary Complaint?_____

_____

How long have you had problem? _____ Have you had this in the past? _____
How does this problem interfere with your daily activities? _____

_____

What makes it better? _____ What makes it worse? _____
Is your condition: ▫ Constant ▫ Intermittent Pain Level: ▫ Low ▫ Slight ▫ Moderate ▫ Severe
Secondary Complaints? _____

_____

Other concurrent therapies_____
How are you responding to your present course of treatment? Better _____Worse _____ Same _____

Surgeries/Hospitalization *(please list dates also)*

_____

_____

_____

Significant Trauma/Accidents _____

Do you have? ▫ Pacemaker ▫ Metal Implants ▫ Pregnant
Allergies _____

Medications (prescription drugs, vitamins, supplements, herbs)
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____
Name_____ Dosage _____

Stress ▫ None ▫ Low ▫ Moderate ▫ Severe Explain Causes:

_____

_____

Exercise (type/frequency) _____

Habits: ▫ Cigarettes ▫ Coffee ▫ Tea ▫ Sodas ▫ Alcohol Drugs _____

Do you? ▫ skip meals ▫ snack ▫ eat large meals ▫ eat when rushed ▫ work and eat ▫ eat but not hungry

Average Daily Diet:

Morning _____

Afternoon _____

Evening _____

Snacks _____

YOUR **MEDICAL HISTORY**

▫ Cancer ▫ HIV+ ▫ Diabetes ▫ Heart Disease ▫ High Blood Pressure ▫ Low Blood Pressure ▫ Stroke
▫ Epilepsy ▫ Asthma ▫ Kidney Disease ▫ Anemia ▫ Bleeding Disorder ▫ STD ▫ Hepatitis ▫ Jaundice
▫ Thyroid Disease ▫ Chronic Fatigue ▫ Sudden Weight Loss ▫ Sudden Weight Gain

Other _____

Dates of Illness _____

FAMILY **MEDICAL HISTORY**

▫ Cancer ▫ Diabetes ▫ Kidney Disease ▫ Heart Disease ▫ High Blood Pressure ▫ Stroke ▫ Epilepsy
▫ Low Blood Pressure ▫ Asthma ▫ Anemia ▫ Bleeding Disorder ▫ Hepatitis ▫ HIV+ ▫ Thyroid Disease

For the following Sections on Organ Systems evaluation,
please check any problems that are frequent, or that have occurred within the past 3 m

Other area _____ ▫ Bones sore/painful ▫ Loss of Grip ▫ Swollen Joints ▫ Weakness
▫ Leg cramps at night ▫ Tingling in feet ▫ Loss of feeling in hands/feet ▫ Muscle spasm/cramps
▫ Stiffness all over ▫ Osteo Arthritis ▫ Rheumatoid Arthritis ▫ Tendinitis ▫ Sciatica

Onset of Pain: _____ Better with? _____ Worse with? _____

Describe the pain (burning/constant/intermittent/pins&needles/numbness/coldness/sharp/dull)

_____

HEAD, EYES, EARS, NOSE AND THROAT

▫ Dizziness ▫ Concussion ▫ Poor Memory ▫ Loss of Balance ▫ Head feels 'Heavy' ▫ Migraines
▫ Headaches (describe) _____
▫ Eye Strain ▫ Eye Pain ▫ Floaters ▫ Blurred Vision ▫ Dry Eyes ▫ Watery Eyes ▫ Itchy Eyes
▫ Ear Ache ▫ Ear Infections ▫ Hearing Loss ▫ Ringing/Buzzing in Ears ▫ Grinding Teeth ▫ TMJ
▫ Teeth Problems ▫ Facial Pain ▫ Facial Paralysis ▫ Sensation of 'Lump' in Throat
▫ Sinus Problems ▫ Mucus ▫ Nose Bleeds ▫ Runny Nose ▫ Congestion ▫ Frequent Colds
▫ Sore Throat ▫ Copious Saliva ▫ Dry Mouth ▫ Difficulty Swallowing ▫ Hoarseness/Loss of Voice

LUNG SYSTEM

▫ Shortness of Breath ▫ Difficulty Breathing ▫ Wheezing ▫ Cough ▫ Asthma ▫ Bronchitis
▫ Pneumonia ▫ Difficulty Breathing When Lying Down ▫ Coughing Blood ▫ Coughing Phlegm

Sputum color? _____ Thick or Thin? _____ Other?_____

HEART SYSTEM

▫ Heavy Sleep ▫ Insomnia ▫ Wake Easily ▫ Nightmares ▫ Difficulty falling asleep ▫ Difficulty staying asleep
▫ Wakes frequently ▫ Wakes early Time? _____ ▫ Excess dreaming ▫ Restless ▫ Sleep Soundly
▫ Night sweating ▫ Snoring ▫ Sleep Apnea ▫ Fainting ▫ Vertigo ▫ Dizziness ▫ Tremors ▫ Fatigue
▫ Cold Feet ▫ Cold Hands ▫ Swollen Hands/Feet ▫ Cold Back ▫ Localized Weakness ▫ Fevers ▫ Chills
▫ High Blood Pressure ▫ Low Blood Pressure ▫ Pain/Pressure Chest ▫ Irregular Heart Beat ▫ Palpitations

SKIN/HAIR

▫ Frequent Rashes ▫ Eczema ▫ Hives ▫ Itching ▫ Purpura ▫ Dryness ▫ Clammy/Moist ▫ Burning
▫ Changes in Moles or Lumps ▫ Bleeds/Bruises Easily ▫ Varicose/Spider Veins ▫ Hair Loss ▫ Dry Scalp
▫ Change in Hair Texture ▫ Scars Other_____

DIGESTIVE SYSTEM

▫ Poor Appetite ▫ Excess Hunger ▫ Feel tired if miss meal ▫ Cold Abdomen ▫ Weight Gain ▫ Weight Loss
▫ Strong Thirst ▫ For cold? ▫ For hot? ▫ Never thirsty ▫ Crave Sweets ▫ Crave Salty ▫ Crave Sour
Specific food craving? _____ Peculiar Tastes or Smells? _____
▫ Heartburn ▫ Nausea ▫ Vomiting ▫ Belching ▫ Abdominal Bloating ▫ Foul Breath ▫ Stomach Pain
▫ Diarrhea ▫ Constipation ▫ Flatulence ▫ Hemorrhoids ▫ Black Stools ▫ Bloody Stools ▫ Mucous Stools
▫ Pain/Cramps ▫ Sensitive Abdomen ▫ Foul Odor ▫ Colitis ▫ Irritable Bowel
BOWEL MOVEMENT: Frequency(#/day) _____ Color_____ Quality (loose/firm)_____
▫ Sudden Energy Drop At _____(time) ▫ Fatique ▫ Heavy Limbs ▫ Weak Limbs ▫ Restless ▫ Energetic

URINARY SYSTEM

▫ Pain/burning with Urination ▫ Pain before Urination ▫ Urgency to Urinate ▫ Incontinence ▫ Blood in Urine
▫ Kidney Stones ▫ Frequent Infections ▫ Strong urine smell ▫ Frequent Urination: ▫ Day ▫ Night
▫ Prostate Enlarged ▫ Elevated PSA ▫ Impotence Other_____
Urine color: _____ Amount: _____

REPRODUCTIVE SYSTEM (for Women)

▫ Pregnant? # of pregnancies____ # of Deliveries ____ # Miscarriages _____ # of Abortions _____
Age Started menstrual cycle_____ Age Stopped _____ Last Monthly Period _____
Period Duration _____ Birth Control Method_____ Last PAP? _____
▫ Heavy Flow ▫ Light Flow Color (pale/dark/red/purple?) _____
▫ Irregular Periods ▫ Scanty Periods ▫ Missed Periods ▫ Dysmenorrhea ▫ Clots ▫ Cramps ▫ Spotting
▫ Vaginal Discharges: ▫Yellow ▫ White ▫ Thick ▫ Thin ▫ Itching ▫ Odor
▫ Breast Lumps ▫ Breast Pain ▫ Menopause ▫ PMS ▫ Fibroids ▫ Endometriosis ▫ Low Libido
▫ Low Backache ▫ Water Retention ▫ Hot Flashes Other_____

EMOTIONAL & NEUROLOGICAL

▫ Seizures ▫ Tremors ▫ Numbness/Tingling ▫ Always Cold ▫ Always Hot ▫ Poor Coordination
▫ Neuralgia (pain) ▫ Shingles Other _____
▫ Nervousness ▫ Depressed ▫ Anxiety/Worry ▫ Easily Angered ▫ Easily Irritated ▫ Stressed
▫ Giddy ▫ Sadness/Grief ▫ Frequent Crying ▫ Mood Swings ▫ Suicidal ▫ Phobias/Fears ▫ Manic
▫ Panic Attacks ▫ Indecisive ▫ Other Emotional _____

Most Favorite:	**Least Favorite:**
Climate _____	Climate _____
Season _____	Season _____
Taste _____	Taste _____
Food _____	Food _____
Time of Day _____	Time of Day _____
Temperature _____	Temperature _____

Thank you for completing this confidential, medical history questionnaire. Your honest, complete answers will assist me in providing you with the best possible health care.

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OUR PATIENT CARE FINANCIAL AGREEMENT POLICY

Effective October 1, 2009

Dear Patient,

Thank you for choosing Cindy Albon LAc,WellStream Acupuncture, as your healthcare provider. We are committed to your treatment being successful, and our office policy has been established to ensure that the best health service can be provided to you and your family. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Full payment is due at the time of your service. We accept cash, check, credit and debit cards.

Missed Appointments and Cancellations

In order to prevent being charged a cancellation fee I agree to give at least 24 hrs notice of cancellation. When we make an appointment, I am reserving time just for you. Sufficient cancellation notice allows us to offer your time to another patient who may be waiting for an appointment. Uncanceled or missed appointments without 24 hr notice will be charged the full amount. For patients arriving more than 15 minutes late, you may be asked to reschedule your appointment if there is not sufficient time to provide the best treatment to you, or to have a shortened session. We will do our best to provide sufficient treatment, schedule permitting. Please help us provide the best care to you by keeping scheduled appointments in a timely manner. Late cancellations due to emergencies are understandable, in those cases the cancellation fee will be waived.

Regarding Insurance

Please remember that medical services are rendered to you, not to your insurance company. Check with your insurer to find out if acupuncture is included in your benefits. We are happy to verify your coverage for you after your first acupuncture session. Important: until we can verify your coverage, payment is due in full at the time of each visit. If you have insurance that covers acupuncture, we will do our best to determine what co-pay amount you are responsible for. We will submit and process your insurance claims to receive partial payment. The full cost of services is ultimately your responsibility, even if your insurance provider denies payment for any portion of your bill for any reason. Some insurance companies send payments directly to the patient and in this case, we ask that you pay for services in full at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your medical insurance programs. Insurance companies do not reimburse for cancelled sessions. Please note that supplements and/or herbal formulas supplied as part of your treatment are not typically covered by insurance.

Rate Schedule

All sessions include Aromatherapy, Sound Therapy and Auriculo-Acupressure

Comprehensive New Patient Initial Consultation, Including Acupuncture Treatment (2 hrs): 145.00
Established Patient Consultation & Acupuncture Treatment (1 hr): 85.00
Cosmetic Facial Rejuvenation (90 min): 130.00 per session
Consultation Only for Acupuncture or Herbs (45 min): 60.00
Cupping Massage (15-20 min): 20.00
Auricular NADA Detoxification (40 min): 35.00
Concierge Services to Patient's Home: Please contact our clinic
Herbal Medicines: prices vary from $7 - 40
Herbal tablets or pills may be returned ***unopened*** for a full refund. No returns or refunds on custom herbal medicine extracts and teas. There is a $25 fee for all returned checks. Payment is due in full at time of service.

My signature below certifies that I have read and understand the above Financial Policy and agree to be responsible for full payment of all services rendered to myself and/or any member of my family.

X _____ **Date** _____
Signature of Patient or Responsible Party

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ACUPUNCTURE TREATMENT INFORMED CONSENT

Welcome to our office!

Chinese Medicine is a healing system that includes multiple therapeutic modalities. This medical system facilitates the body's innate healing capacity and requires participation in taking personal responsibility in assisting one's own health recovery. In some cases, symptoms may relapse or intensify temporarily during the course of treatment before relief is attained. The patient is a partner with the acupuncturist in the healing process. The statements below describe the treatment modalities which may be employed during the course of treatment and will assist your understanding of and participation in the healing process.

Acupuncture is a technique utilizing fine sterile disposable steel needles inserted at specific points in the body to cause a positive response in order to correct various ailments. The location of the application of the needles and the depth of their insertion is determined by the nature of the problem. The application of these needles may be accompanied by some painful sensations and there is a slight possibility that minor swelling, bleeding, discoloration or hematoma (bruising) may occur at the site of insertion. A sensation of momentary euphoria or light-headedness may occur after the acupuncture treatment. Fainting is possible, but rare, unless you have not eaten. Please notify us immediately if you experience any of these symptoms or problems.

Electrical Stimulation ("E-STIM") of the acupuncture needles involves using a small battery-powered stimulator attached by electrodes to the ends of the needles. A slight throbbing or tingling sensation may be felt during the use of this stimulator. Electrical stimulation may also be employed independently from acupuncture needles. These modalities are usually employed for pain management and other specific conditions.

Cupping utilizes round suction cups over a large muscular area such as the back to enhance blood circulation to the designated area. This method may produce deep redness, discoloration, and on rare occasion a minor blister may form that may persist up to several days but will eventually disappear.

Tuina is a specialized body work technique utilized in facilitating healing and pain management. There occasionally may be increased soreness or bruising at the sites of the treatment.

Herbal Nutrients are used to facilitate the body's own restorative processes. These herbs are usually taken as a tea by mixing plants extracts with liquid. Herbs may also be supplied in Tablet or Pill form to be taken with water. Chinese herbal formulas can tend to taste bitter as they are made mostly from roots, bark, leaves and other parts of a plant. On rare occasions, temporary gastric upset may occur. If any discomfort persists, accompanied by hives or shortness of breath, discontinue the herbs and advise us immediately.

Auricular (Ear) Acupuncture/Acupressure is the insertion of special needles into specific points of the ear, each point corresponding to an organ or body system. This method used for NADA detox treatment. If you feel excessive pain during your session, inform the practitioner so that your treatment can be altered. Herbal (Vaccaria Seeds) or magnets may be employed for acupressure to the ear. This method is used generally for most conditions.

Moxibustion is the application of indirect heat supplied by burning the herb Folium Artemisiae vulgaris, more commonly known as "Mugwort Plant", over a single or group of acupuncture points. The area of treatment may remain red and warm for several hours afterwards. In rare incidence, a minor burn may occur at the site of moxibustion. Please notify us immediately if you experience any of these symptoms or problems.

Please ask any questions you may have about treatments
PLEASE KEEP THIS PAGE FOR YOUR RECORDS

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PRIVACY RIGHTS/HIPAA NOTICE

Our office is dedicated to providing service with respect for privacy.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is uses or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent

Authorization for *other uses* of Protected Health Information (PHI)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Specific description of the information to be used or disclosed, including the specific purpose: Office promotions, holiday & or birthday cards, newsletters, change of address
Individuals who may use or disclose this information.
Expiration date of this Authorization: Ongoing until patient indicates in writing otherwise
The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and my no longer be protected by the privacy rules.
By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

I hereby acknowledge that I have received a copy of WellStream Acupuncture's Notice of Privacy Practices.

Patient Name (Please Print)_____

Patient Signature _____ Date _____