Acupuncture Appointments

1. Please bring your new patient questionnaire filled out with you to your first appointment.

2. Please bring or wear loose clothing (shorts, t-shirts) to each appointment.

3. Please eat a light meal or snack before your appointment; an empty stomach may cause dizziness.

4. Please DO NOT eat or drink food that may change the color of your tongue or brush your tongue the day of your appointment. (coffee, soda, juice)

5. Please verify with your insurance company to see if you have acupuncture benefits prior to your treatment. If you do not have coverage ask your insurance company if they will pay if a medical doctor gives you a referral.

What to expect at your first visit?

Your first visit will take approximately one hour and will include an acupuncture treatment. We will discuss your health questionnaire and any concerns you have prior to the treatment. I will come up with a diagnosis, a treatment plan and a few suggestions regarding your condition. If you have any questions please do not hesitate to email me at ldcljd@gmail.com I look forward to working with you.

Thank you,
Jidong Li, D.O.M, A.P.
Dongcheng Li, D.O.M, A.P.

New Patient Questionnaire

Acupuncture Intake Form Date:

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. This information is considered confidential. Please fill it out as completely as possible even if you do not feel certain questions pertain to your present condition. Thank You.

Name: ____

Address: ____

City________________________ State_______ Zip_________________

Email:____

Phone: (Cell) ____________________ (Home) _____________________

Height: __________ Weight: ________ Sex: ________

Date of Birth: __________________ Age: __________

Employer: ___________________________________

Occupation: ___________________________________

Social Security #: ________________________________

Single/Married/Divorced/Widowed/Other (circle)

Physician: _____________________________________

Referred by: ___________________________________

In Emergency, Notify: ____________________________

Relationship: _________________ Phone: ______________________

Insurance Carrier: ________________________ ID#________________________

Main problem/s you would like help with:

1.

2.

3.

When did the problem/s begin (be specific):

To what extent does the problem/s interfere with your daily activity (work, exercise, sleep, sex, etc.)?

Have you been given a diagnosis for the problem/s? If so, what?

What kind of treatments have you tried? Other concurrent therapies:

Medications

What medications are you currently taking? Please list name, reason, dosage.

Habits

Do you have a regular exercise program? Please describe.

Please indicate usage per day or per week:

Water ______ ounces per day

Coffee ______ ounces per day

Tea ______ day/week (circle)

Alcohol ______ day/week Type liquor/beer/wine

Soft Drinks ______ day/week

Cigarettes ______ day/week

Sweets ______ day/week

Please describe your average daily diet: Be specific.

Morning:

Snack:

Lunch:

Snack:

Dinner:

Supplements/Herbs/Vitamins/Minerals: (Please list brand, product name, & reason for taking)

Muscles/ Bones/ Joints

Do you have pain or tightness? No / Yes If Yes, please indicate the location on the chart below.
The pain is (circle all that apply):

Sharp Dull Aching Numb Superficial Pain

Burning Tingling Shooting Deep Pain Pain worse in am/pm

Pain worse/better with heat Pain worse/better with cold Pain worse/better with pressure

I have (circle all that apply):

Swollen joints Arthritis/joint pain Tendonitis Muscle cramping

Muscle pain Repetitive Strain Injury Bone Pain Fractured Bone(s)

Where?_______________

Please explain any injury's in the space provided:

Date of onset:

Location:

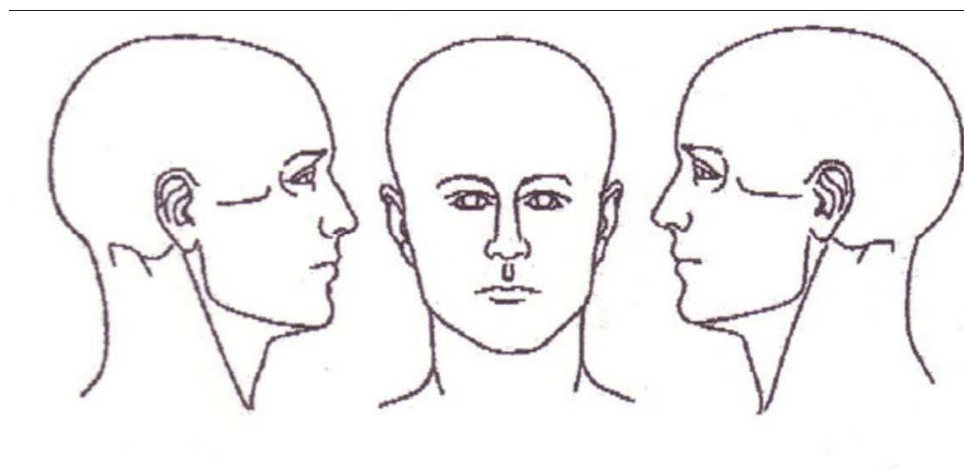
Duration of pain:

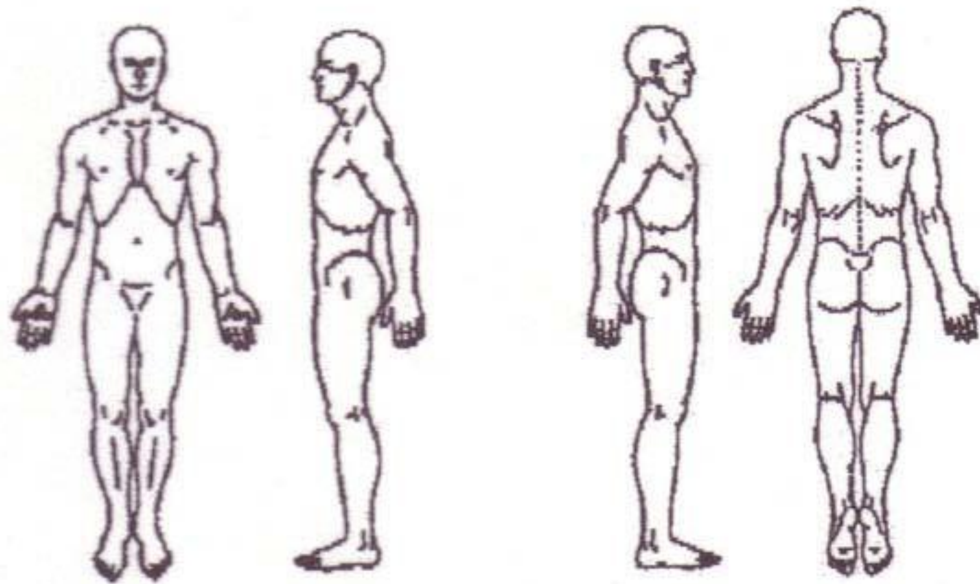
Aggravating factors: (ex. Heat)

Alleviating factors: (ex. Cold)

Treatments: (ex. Ibuprofen, chiropractic)

Please indicate areas of pain or distress:





Energy:

How is your energy? Please circle. low1 2 3 4 5 6 7 8 9 10 high

What time of day is your energy:

Highest: 6am-12pm/1pm-5pm/6pm-12am & **Lowest**: 6am-12pm/1pm-5pm/6pm-12am

Do you fatigue easily? Yes/ No

Emotions & Sleep:

How do you feel emotionally?

Do you have (circle all that apply):

Panic attacks   Depression   Anxiety   Bad temper

Nervousness   Fear attacks   Poor memory   Difficult concentration

Are you in a relationship? Yes / No

How do you feel about your relationship? Good/ Fair/ Poor

How do you handle stress?

How do you relax?
How do you feel about your work?

How long do you normally sleep? _________hours per night

I have difficulties with (circle all that apply):

Falling asleep   Staying asleep   Dream-disturbed sleep

Waking up at about _____am/pm and not being able to fall asleep again

Gastrointestinal:

I have (check all that apply):

Belching   Nausea   Vomiting   Ulcers   Bloating

Heartburn   Hernia   Acid Reflux   Severe stomach pain   Other:__________________

Bowel movements: How often? _________time(s)/day or _________days/week

I have (circle all that apply):

Irregular Bowel Movements   Constipation   Diarrhea   Undigested food in stool

Burning sensation   Hemorrhoids   Itchiness   Painful bowel movements

Loose stool   Hard stool   Blood in stool   Gas

Urination:

Urination: How often? ______ times per day Color: Pale yellow / Dark yellow/orange

I have or had (circle all that apply):

Trouble starting stream   Frequent urination   Incontinence   Dribbling when sneezing

Burning Pain   Blood in urine   Kidney stones

Urinary tract infections   Other_____________

Women Only:

Are you pregnant: Y / N

Age of first menses: _____

Number of days between cycles:______

Number of flow days:_____ Typical Color: dark red/ bright red/ pale red

I have or had (check all that apply):

Irregular menstruation   Heavy flow   Light flow   No flow   Clots

Vaginal itching/burning   Spottin g between periods   Discomfort/pain before period

Irritability Breast Tenderness Cravings Cramps

Vaginal discharge? No / Yes _ Color___________________

Number of pregnancy's __________ Number of Children:_________

Men:

I have (circle all that apply):

Prostatitis Impotence Penis blood/mucous/discharge Reproductive problems

Other:____

Eyes, Ears, Nose, Throat, & Head:

Do you smoke? No / Yes ______ per day, for _______ years

I have (check all that apply):

Frequent colds Chronic runny nose Frequent sore throat Chronic cough Allergies

Coughing blood Cough up mucous Pain inhaling Asthma Clogged/popping in ears

Nose bleeds Painful/red eyes Poor vision See spots/floaters Dizziness

Bleeding gums Dry mouth Ear pain Ringing in ears

Shortness of breath on exertion/ or at rest Frequent headaches/migraines

Cardiovascular:

I have (circle all that apply):

Chest pain Palpitation Varicose veins Phlebitis Cold hands and feet

Irregular heart beat Poor circulation Hypertension

Other:_____________________________________

Skin & Hair:

I have or often have (circle all that apply):

Dry skin Skin rashes Itching Acne Eczema Hives

Hair loss Premature graying Age spots

Other:______________________________________

Financial Policy

As a courtesy, we will bill your insurance company if you have acupuncture benefits. We cannot bill health insurance for conditions that are not covered by your plan. **You are expected to pay on the day of service.** If we receive reimbursement for you treatments they will be applied to your account as a credit or a check can be made out to you. Expect payment within 6-8 weeks of the start of your first treatment.

A $45 fee will be charged for missed appointments or cancellations without a 24 hour notification.

Payment is due at time of service for non-insurance patients.

FEE SCHEDULE

ACUPUNCTURE

Initial Visit	**$125**
Follow-up Visits	**$75**

HERBAL MEDICINE

By Customized Herbal Formulas

_______________________________ _______________________

Signature Date

____

Please Print Name

GLOBAL TRADITIONAL CHINESE MEDICINE ACUPUNCTURE CLINIC
INFORMED CONSENT TO CHINESE MEDICAL HEALTH CARE

Information for Patients

Nature of Treatment: I understand that methods of treatment may include but are not limited to, acupuncture, Moxibustion, cupping, electrical stimulation, Tui-Na (Oriental massage), dermal friction (Gua Sha), infra-red (heat lamps), Oriental herbal medicine, and nutritional counseling based on the fundamentals of Chinese medicine.

Purpose of Treatment: The purpose of the treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on an Oriental system of medical theory. Diagnosis and treatment, based on these theories are used to promote health and treat organic or functional disorders.

Benefit of Treatment: Acupuncture and Oriental Medicine procedures have been used effectively to treat disease for hundreds of years. The World Health organization lists 43 conditions, which may effectively be treat by Chinese medical methods. These include muscular-skeletal injuries, digestive disorders, respiratory diseases, women's health issues, etc. We cannot guarantee the outcome of any course of treatment.

Risks of Treatment: Acupuncture and Oriental medicine have been shown to be relatively safe. However, these are some uncommon but potential risks. These potential risks may include but are not limited to:

- Discomfort during and after the insertion of a needle
- Dizziness, fainting, nausea
- Localized, minor bruising or swelling
- Minor burns with the use of Moxa
- Gastro-intestinal upset with the use of Chinese herbs (if this occurs, please consult with your practitioner so that your formula can be modified)
- Possible, temporary aggravation of symptoms that existed prior to treatment
- A broken needle (rare with the use of disposable needles)

Please notify your practitioner if you have any adverse effect from treatment.

Special Situations: Some herbs and acupuncture points are contraindicated during pregnancy. Please notify us if you might be pregnant, have severe bleeding disorders, take blood thinning medication or if you are wearing a pacemaker or other electronic medical device.

Use of Herbs:
I understand that Chinese herbs may need to be prepared for me and the teas, pills or tablets consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify a member of the clinical staff if I experience any unanticipated or unpleasant effects associated with the

consumption of the herbs.

Use of Disposable Needles: To reduce the possibility of infection from acupuncture, all needles are pre-sterilized, one-time-use needles made of surgical stainless steel needles. After each treatment they are disposed of as medical waste, needles are never reused. Additionally, your acupuncturist has had training in Clean Needle Technique and Universal Precautions.

Consent

I request and consent to the performance of acupuncture and Oriental Medicine procedures. I understand that I am free to withdraw my consent and that I may stop treatment. I understand that if I have any questions about this information, I should ask my acupuncturist. I, hereby release Global Traditional Chinese Medicine Acupuncture Clinic and its employees, practitioner and officers from any and all liability that may occur in connection with the above-mentioned procedures, except in the unlikely event of gross negligence.

Patient's Print Name

____ Date:____________________

Patient's Signature

____ Date:____________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Pledge Regarding Your Medical Information

We respect legal obligation to keep health information that identifies you private. As obligated by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We do not use your health information in our office or disclose it outside of our office without your written permission. In some limited situation, the law requires us to disclose your health information without either a written or verbal consent.

Disclosure of Patient Health Care Information

Use and Disclosure

We will ask you to sign a consent form allowing us to use and disclose your health information for purposes of treatment, payment and healthcare operations in this office. We are allowed to refuse to treat you if you do not sign the consent form. We are permitted to use and disclose your healthcare records for the purpose of treatment, payment, and healthcare operations.

TREATMENT, PAYMENT, HEALTHCARE OPERATIONS

We may disclose patient health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example, on occasion, it may be necessary to seek consultation regarding a patient's condition from other health care providers associated with Global Traditional Chinese Medicine Acupuncture Clinic.

Qualified staffs in our clinic may share patient's health care information and disclose information to other health care providers outside this clinic in order to coordinate your care such as scheduling lab work and ordering x-rays. Please be advised that, on occasion, health care information may be inadvertently disclosed in the process of consultation and treatment.

EMERGENCIES

We may disclose patient health information to notify or assist in notifying a family member, or another person responsible for the patient's care, in the event of an emergency or patient death.

PUBLIC HEALTH RISKS

As required by law, we may disclose patient health information to public health authorities for 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 (FDA) about problems with products and reactions to medications, and reporting disease or infection exposure.

PUBLIC SAFETY

It may be necessary to disclose patient health information 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.

LAW ENFORCEMENT

We may disclose patient health information 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.

REQUIRED BY LAW

We will disclose patient health information when required to do so by federal, state or local law.

HEALTH OVERSIGHT ACTIVITIES

We may disclose patient health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws. Unless you request otherwise, we may use or disclose health information to a family member or other personal representative to the extent necessary to help with your health care or with payment for your health care. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

APPOINTMENT REMINDERS

We may call a patient's home to confirm a scheduled appointment. If the patient is not at home, we leave a reminder message on the answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of the scheduled appointment along with a request to call our office if there is a need to cancel or reschedule the appointment.

Patient Rights Regarding Health Information

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

RIGHTS TO INSPECT AND COPY

Patients have the right to inspect and copy their health information. We may charge for the costs of copying, mailing or other associated supplies. To request inspect and/or copy health information, please complete and submit REQUEST TO INSPECT OR COPY HEALTH INFORMATION FORM.

RIGHT TO AMEND

Patients have the right to request that Global Traditional Chinese Medicine Acupuncture Clinic amend their protected health information, if they believe their health information we have is incorrect or incomplete. Patients have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM.

Please be advised, however, that Global Traditional Chinese Medicine Acupuncture Clinic is not required to agree to amend protected health information. We may deny the request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny the request if the patient asks us to amend information that:

A. We did not create, unless the person or entity that created the information is no longer available to make the amendment.
B. Is not part of the health information that we keep.
C. You would not be permitted to inspect and copy.
D. Is accurate and complete.

If the patient request to amend health information has been denied, the patient will be provided with an explanation of our denial reason(s) and information about how to disagree with the denial.

RIGHT TO AN ACCOUNTING OF DISCLOSURES

Patients have a right to receive an accounting of disclosures of their protected health information made by Global Traditional Chinese Medicine Acupuncture Clinic. This is a list of the disclosures we made of medical information about the patient for purposes other than treatment, payment and health care operations. We may charge for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. To request accounting of disclosures, please complete and submit REQUEST FOR ACCOUNTING OF DISCLOSURES FORM. If you would like to request that an accounting of disclosures be released to another individual or entity, you must also submit AUTHORIZATION TO DISCLOSE HEALTH INFORMATION FORM.

RIGHT TO REQUEST RESTRICTIONS

Patients have the right to request restrictions on certain uses and disclosures of their health information. To request restrictions, please complete and submit REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION FORM.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS
Patients have the right to have their health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon their request. For example, patients can ask that we only contact them at work or by mail. To request confidential communications, please complete and submit REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION FORM.

Patients have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Responsibilities of Global Traditional Chinese Medicine Acupuncture Clinic

Global Traditional Chinese Medicine Acupuncture Clinic is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.
As permitted by law, Global Traditional Chinese Medicine Acupuncture Clinic reserves the right to amend or modify our privacy policies and practices at any time in the future. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Questions and Complaints

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information, you can file a complaint about Privacy rights by contacting the Privacy Officer/Administrator. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Patient's Print Name

____ Date:___________________

Patient's Signature

____ Date:___________________