Embodied Acupuncture Samantha Mason MSOM LAc

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New Patient Questionnaire and Health History

Patient Information

Name____ Today's date ______ /______ /____________

Date of Birth ______ /______ /____________ Age _________ Gender Identification ________________________________

Address______________________________________ City ____________________ State ______ Zip ______________

Email ______________________________________ Best contact Phone # (________)________-____________

Emergency Contact ________________________ Relationship ______________ Phone # (________)________-____________

Primary Care Provider (MD/ND) ______________________________ Phone # (________)________-____________

How did you hear about Embodied Acupuncture? ____

Is this your first time receiving acupuncture? ☐ Yes ☐ No

Insurance Information (If cash pay, continue to next section)

☐ **MVA:**

Insurance Company ______________________________________ Claim # ______________________________

Claims Adjuster ____ Phone # ______________________________

☐ **Workers Comp:**

Employers Name: ____

Insurance Company: ____________________________________ Phone # ______________________________

Send Claims to Address: ____

Claim #: ______________________________ Claim Officer: ____

Health Information

What is the primary reason for your visit today? ____

How long has this been a concern? ____

What other treatments have you tried to address this concern? ________________________________

____

Please list any other health concerns you would like to discuss (physical, mental, emotional):

____

____

Have you ever been hospitalized? If so, what for (with approx. dates):

____

____

Please list any medications/supplements you are currently taking:

____

Please list any allergies: ____

How many hours of sleep a night on average? ___________ Do you wake feeling rested? ☐ Yes ☐ No

Is there a time of day when your energy tends to be lowest? ____________________ highest? ________________________

Please check if you have experienced any of the following in the last three months:

☐Headaches ☐Dizziness ☐Eye pain ☐Dry eyes ☐Ringing in ears ☐Visual floaters

☐Poor balance ☐Tremors ☐Fatigue ☐ Sweat easily ☐Tend to feel hot ☐Tend to feel cold

☐Insomnia ☐Cravings ☐Weight loss ☐Weight gain ☐Change in appetite ☐Easy bruising

☐Cold feet ☐Constipation ☐Diarrhea ☐Gas/bloating ☐Painful urination ☐Poor Appetite

☐Abdominal cramping ☐Hemorrhoids ☐Visual floaters ☐Difficult urination ☐Heartburn/reflux

☐Fatigue after eating ☐Anxiety ☐Depression ☐Panic attacks ☐Suicidal thoughts

☐Peculiar taste in mouth ☐Chills ☐Weak limbs ☐Night sweats ☐Cold hands

How many days a week do you exercise? ________________ Type? ____

How do you deal with stress in your daily life? ____

____

Family Medical History (please specify self or family member)

☐ Cancer ____ ☐ Kidney Disease ____________________________________

☐ Heart Disease __________________________________ ☐ High BP ____

☐ Diabetes______________________________________ ☐ Arthritis ____

☐ Osteoporosis __________________________________ ☐ Anxiety ____

☐ Depression ___________________________________ ☐ Mental Illness _____________________________________

Biological Male only

Do you get regular screening tests done by your doctor (blood work, prostate exam)? ☐ Yes ☐No

Date of last prostate examination? (month/yr) _______ /____________

Have you experienced any of the following?

☐ Testicular pain ☐ Hernia ☐ Discharge ☐ Sores ☐ Numbness/tingling in genitals

Biological Female only

Are you currently pregnant? ☐ Y ☐ N If yes, how many weeks__________ Post menopausal? ☐ Y ☐ N

# of pregnancies __________ # Births __________ # Miscarriages __________ # Abortions __________

Date of your last period: _____/___________ # days of bleeding _________ Average Length of cycle _________________

Currently using birth control? ☐ Yes ☐No If Yes, Type ____________________ Length of use _________________

Please describe any changes (physical, mental, emotional) you experience prior to your cycle (PMS Symptoms):

____

____

Have you experienced any of the following in the past or present:
☐ Missed period ☐ Ovarian cysts ☐ Abnormal Pap ☐ Endometriosis ☐ Breast Lumps

Consent to Treatment

I voluntarily consent to acupuncture and other procedures associated with the practice of Embodied Acupuncture provided by Samantha Mason, a licensed acupuncturist in the state of Oregon. I understand that acupuncturists practicing in the state of Oregon are not primary care providers and that it is recommended that all patients have a primary care provider as part of a complementary care program.

I understand that methods of treatment may include but are not limited to: acupuncture, moxibustion, guasha, TDP lamp therapy, cupping, electro stimulation, and bodywork therapies.

Adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, temporary pain or discomfort, and temporary aggravation of preexisting symptoms. Burns and/or scarring are a potential risk of moxibustion and TDP lamp therapy.

I understand that Chinese Herbal Medicine may be recommended and that I am not required to take these substances. If I do decide to take them I agree to follow the directions for administration and dosage. Adverse side effects may result from taking these substances. These include, but are not limited to, changes in bowel movements, temporary abdominal pain or discomfort, and possible temporary aggravation of preexisting symptoms. If I experience any issues that I believe may be associated with the taking of these substances, I agree to contact Samantha Mason LAc as soon as possible with my concerns.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment. I have been informed about the risks and benefits of acupuncture and other associated procedures, and have had an opportunity to ask questions. I understand that this consent form covers the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: ______________________________________ Date: ______________________

To be sign by patient's representative if the patient is a minor or physically or legally unable to sign on their own behalf.

Patient Representative (if applicable): ____

Representative Signature: ________________________________ Date: ______________________

Policies and Financial Agreement

To help serve you better, I've listed some guidelines and office policies to review prior to your visit.

ACUPUNCTURE APPOINTMENT GUIDELINES:

All visits are 50-75 minutes, depending on need
Please eat at least 2-3 hours prior to your appointment time
Wear loose fitting clothing if possible

FOLLOWING YOUR TREATMENT:

Avoid strenuous activity, a few hours of relaxation is best
Avoid alcohol for 24 hours -consuming alcohol may produce adverse effects
Enjoy a light meal including proteins and vegetables. Avoid heavy foods including fried foods, dairy, and desserts. Drink plenty of water
I am available at any point following your appointment if you have questions. Do not hesitate to make contact: EmbodiedAcu@gmail.com Consultation line: 206-866-4680

TIME OF SERVICE RATES:

$125 for each 75 minute Comprehensive Follow up session
$95 for each 50 minute Acupuncture only Follow up session
Cash, check, and credit card payments are accepted. Due at time of service.
A superbill is available if you would like to submit to insurance. Please inform me if you are interested in a receipt following your session.

CANCELLATION POLICY

There is a 24-hour cancellation policy. Please call to cancel or reschedule your appointment. All visits cancelled with less than 24 hour notice will be charged a $50 cancellation fee for the first incident, and the full time of service rate for any following incidents.

CLIENT ACKNOWLEDGEMENT

I have read the preceding information and have been given the opportunity to ask questions clarifying the content. I understand that I am financially responsible for all charges and agree to pay for the services rendered. I understand the contents of this disclosure and agree to abide by these policies.

Patient Signature:_______________________________________ Date: ______________________________

Medical Notice of Privacy Practices (HIPPA)

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

Embodied Acupuncture respects our legal obligation to keep health information that identifies you private. We do not use your health information inside our office our outside without your written permission. In some limited situations, the law requires us to use and disclose your health information without your permission.

These examples include:
-For public health purposes, such as contagious disease reporting and notices to and from the FDA regarding drugs and medical devices.
-Disclosure to government authorities about victims or suspected abuse, neglect, or violence.
-Uses and disclosures for health oversight activities, such as for the audits by Medicare, or for investigation of possible violations of health care laws.
-Disclosures in response to subpoenas of orders of the court.
-Disclosures for law enforcement purposes, such as to provide information about someone who is suspected to be a victim of a crime, or to provide information about a crime in our office.
-Disclosure related to worker's compensation programs.

We are permitted to use and disclose health information to a family member or other personal representative to the extent necessary for treatment or payment related to your healthcare. In addition, we may use your confidential information to remind you of appointments by leaving you messages at home or work. Any other uses and disclosures will be made only with your written authorization.

You have the right to:
-Request restrictions on certain uses and disclosures of protected health information, including those related to the disclosure of family members, other relatives, close personal friends, or any other person identified by you.
-The right to amend your protected health information.
-The right to obtain a paper copy of this notice at your request.
-You have the right to file a formal, written complaint with the Secretary of the US Department of Public Health and Human Services in the event you feel your privacy rights have been violated.

I, ______________________________ (patient name), have read and acknowledged the Notice of Privacy Practices form offered by Embodied Acupuncture, have had the opportunity to ask any questions I have regarding this information, and have received, if desired, a copy of the Notice of Privacy Practices for my own records.

Patient Signature: ______________________________ Date: ________________