Chen's Acupuncture Associates

Cascadia Office Park • 14670 NE 8th Street • Suite 105 • Bellevue, WA 98007
Phone: (425) 644-2056 • Fax: (425) 641-7081

The following information is important to the maintenance of your account and/or your care. Please complete all the questions asked to the best of your ability. Do not hesitate to ask for assistance if needed. We will be happy to help you.

PATIENT INFORMATION:

Name_____Age_____Date of Birth_____

Male____Female _____Married_____Divorced____Single_____Separated_____Widowed_____

Address_____City_____State_____Zip_____

Cell Phone _____ Work Phone_____Email _____

Occupation_____Employer _____

RESPONSIBLE PARTY (if under 18):

Name of responsible party_____Relationship_____

Address_____City_____State_____Zip_____

Cell Phone_____Work Phone _____Email _____

PATIENT MEDICAL HISTORY:

Major complaints in order of significance to you:

1._____2._____

3._____4._____

How do these conditions impair your daily activities? _____

Other physicians seen for the condition: Yes ____No ____

Name of your primary physician: _____

Current medications:_____

Supplements:_____

Hospital Visits / Surgery: _____

Allergy: _____

How did you hear about the office _____

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PATIENT CONSENT

The law requires patients receiving acupuncture to give their informed consent prior to receiving treatment. Informed consent is for the patient to be advised of the practitioner's credentials and the scope of the practice of acupuncture in the State of Washington.

Peishan Chen, LAc., is licensed in the State of Washington (# AC536). She was a physician in the field of Obstetrics and Gynecology at Shantou Hospital in Shantou, China, prior to immigrating to the United States. Peishan Chen received her acupuncture degree from the Northwest Institute of Acupuncture and Oriental Medicine in Seattle from 1996 to 1999. She is not a licensed MD in the U.S.
Ruiya Ma LAc., is licensed acupuncturist in the State of Washington (#AC61212846). She received diplomate of acupuncture and Chinese herbology from the national certificate commission for acupuncture and oriental medicine (NCCAOM) after finishing her education at Bastyr University in Seattle.

As stated by law, therapy acupuncturists in the State of Washington are allowed to use the methods listed following:

Use of acupuncture needles to stimulate acupuncture points, Use of electrical, magnetic, or mechanical devices to stimulate acupuncture points, Moxibustion (direct or indirect application of heat on acupuncture points using herbal materials) Acupressure, Cupping, Dermal friction Infra-red light, Sono-puncture (ultrasound) Laser puncture, Dietary advice based on traditional Chinese medical theory Point injection (use of hypodermic needle to inject solutions)
This in no way means that all these methods will actually be used for your treatment. You will be advised before any of these methods are to be applied, and you always have the right to decline.
Side effects may include, but are not limited to, the following: ome pain following treatment in insertion area, Minor bruising, Infection, Needle sickness; and Broken needle

Patients with the following conditions must inform the practitioner prior to receiving acupuncture treatments.
Please check the following that applies.

_____ pregnancy
_____ pacemaker
_____ severe bleeding disorders
_____ hepatitis
_____ AIDS or HIV positive

I, the undersigned, have read and understood the foregoing information and voluntarily consent to the use of the above procedures for treatments. I understand that there is no guarantee implied or expressed regarding the success or effectiveness of a treatment or a series of treatments. I hereby release Peishan Chen, LAc., from all liability in connection with these treatments. I understand further that I am free to withdraw my consent and stop treatment at any time.

Patient Signature_____Date _____

Patient Name (please print) _____

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NOTICE OF PRIVACY PRACTICES – HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

MEDICAL RELEASE TO INSURANCE COMPANY

I authorize the release of medical information to my insurance company / companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request by insurance company / companies to pay directly to Chen's Acupuncture Associates, PS for those medical services.

CANCELLED/MISSED APPOINTMENTS AGREEMENT

Patient understands that a missed appointment (No Show) will result in full charges being issued for that appointment. Patients arriving later than 15 minutes past the appointment time are not guaranteed their appointment time slot, and will be charged for the appointment in full. If a patient fails to give the clinic 24 hours notice for the change of appointment, the patient will be charged a $25 fee for that appointment.

FINANCIALLY RESPONSIBLE FOR FEES AGREEMENT

I_____(patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment. I also understand that a monthly interest rate of 1.5% will be applied to any unpaid patient balance over 30 days past due.

By my signature below I acknowledge receipt of above polices:

_____ _____

Patient or legally authorized individual signature Date

_____ _____

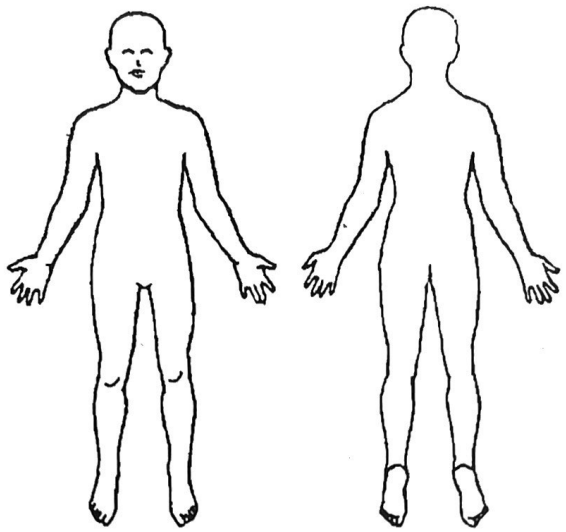
Printed name if signed on behalf of the patient Relationship (Parent, Guardian, Personal Representation)

Clinical Verification of Signatures_____Date _____

CHEN'S ACUPUNCTURE ASSOCIATES

Name: _____ Date: _____

Mark areas of pain or other symptoms on the drawing below:



CIRCLE ALL THAT APPLY

Compare how you feel right now with how you felt before your last treatment:

Better Same Worse New Condition

Explain new condition _____

What are your symptoms?

Pain Dizziness Numbness Tired

Other _____

Describe the pain (if applicable):

Sharp Sore Tingling Burning

Aching Radiating Other _____

Draw a vertical line (|) on the scale below to indicate the severity of your pain (if applicable)

No Pain _____ Worst Possible Pain

How did you feel after your last treatment?

Great Good Okay Tired Dizzy Sore Bad

Other _____

_____

PATIENT SIGNATURE