

## Confidential Patient Information Sheet

### Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_ Have you had acupuncture before?  Yes  No  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Sex:  Male  Female Date of birth \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
In emergency notify (name): \_\_\_\_\_ Emergency phone number: \_\_\_\_\_  
Marital Status:  Single  Married  Domestic Partner  Divorced  Widowed  Separated  
Number of children: \_\_\_\_\_ Ages of children: \_\_\_\_\_ Number who live with you: \_\_\_\_\_  
Others living with you: \_\_\_\_\_  
Primary Care Doctor \_\_\_\_\_ Last seen: \_\_\_\_\_  
How did you hear about our clinic:  Yellow Pages  New Vision Ad  Article  A Talk  
 Brochure  Business Card  Web site  New Times Ad  Referred by: \_\_\_\_\_

### Medical History

Reason for your visit here today: \_\_\_\_\_  
\_\_\_\_\_  
Are you being treated for this condition by anyone else:  Yes  No  
If Yes, who? \_\_\_\_\_ Phone number: \_\_\_\_\_  
Has this condition been diagnosed by a MD?  Yes (Diagnosis: \_\_\_\_\_)  No  
Have these treatments helped?  Yes  Somewhat  Not much  Not at all  
How does this condition affect you? \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_  
Do you currently have any infectious diseases?  Yes  No  Possibly  
If Yes, please identify:  HIV +  Hepatitis B  Hepatitis C  Flu / Cold  Streptococcus  
 Mononucleosis  Tuberculosis  Other: \_\_\_\_\_  
Known or suspected allergies: \_\_\_\_\_  
Childhood diseases you have had:  Chicken Pox  Measles  Mumps  Rheumatic Fever  
 Diphtheria  Scarlet Fever  Other \_\_\_\_\_  
Accidents / Hospitalizations / Surgeries in the past 10 years:  
Reason \_\_\_\_\_ Date / Year(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Your general health as a child:  Excellent  Good  Average  Poor

**Medications**

**Please list all prescription and over the counter medications you are currently taking:**

Drug Name	Reason for taking	For how long	Dose	Frequency

**Please list all supplements and herbs you are currently taking:**

Supplement	Reason for taking	Potency	Frequency

**Lifestyle**

*(Daily amount used within the past 2 months)*

Tobacco:  Yes  No Amount: \_\_\_\_\_ Alcohol:  Yes  No Amount: \_\_\_\_\_

Coffee:  Yes  No Amount: \_\_\_\_\_ Recreational Drugs:  Yes  No Amount: \_\_\_\_\_

Do you feel you are at or near your ideal weight?  Yes  No

Do you feel you have enough energy?  Yes  No      Are you vegetarian or vegan?  Yes  No

Do you feel rested after a nights sleep? \_\_\_\_\_ Do you remember your dreams? \_\_\_\_\_

*Typical day's meals:*

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks / Other: \_\_\_\_\_

Food cravings: \_\_\_\_\_

Religion or other spiritual practice: \_\_\_\_\_

Hobbies or other recreation: \_\_\_\_\_

What kind of physical exercise to you do regularly? \_\_\_\_\_

**Emotions / Relationships**

Number of biological Brothers: \_\_\_\_\_ Sisters: \_\_\_\_\_ Were you adopted?  Yes  No

Your place in the birth sequence #: \_\_\_\_\_

Did you feel safe and nurtured as a child?  Always  Usually  Sometimes  Never

Please feel free to express any concerns or thoughts you feel may be relevant to your health below:  
Use the diagram if desired.

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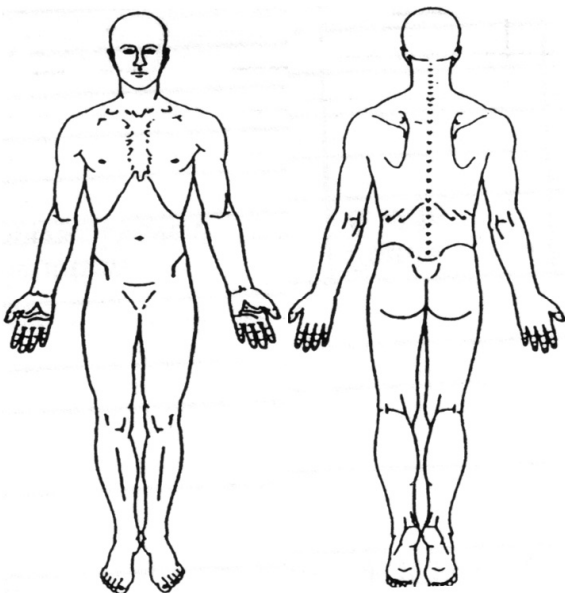
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**The above information is true to the best of my knowledge.** I understand and accept that I am responsible for full payment of my account and that payment is expected at the time of service. I also understand and accept that I am expected to notify Oasis Acupuncture 24 hours prior to any cancellations or changes to my appointment times and that if I do not I may be charged for the appointment.

**X** Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian (if applicable) \_\_\_\_\_

Would you like to receive a free email newsletter?  Yes  No

## **Payment Agreement & Cancellation Policy**

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

- Payment is always due at the time of service.
- We accept the following forms of payment:
  - Cash
  - Check
  - Debit Card
  - Visa
  - Master Card
- We do not accept insurance, however:
  - If you have a PPO-style plan (these are plans that allow you to see doctors who are not part of your insurance company's provider network), we can do the following:
    - Prepare a health insurance claim form that you can submit to your insurance company to request reimbursement of your visit charges.
    - Bill your insurance company for labs and imaging studies.
    - We can never guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.
- All new patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment.
  - New Patient Appointments:
    - If you cancel your appointment with less than 48 hours' notice, or fail to show for your appointment without notification, your credit card will be charged \$100.
    - If you call to cancel your appointment with less than 48 hours' notice and choose to reschedule another appointment at that time, your credit card will be charged \$50.
    - If you reschedule your appointment and then cancel with less than 48 hours' notice, or fail to show for your appointment without notification, your credit card will be charged for the full price of the visit.
  - Follow-Up Visits:
    - If you cancel a follow-up visit the day of your scheduled appointment, or fail to show for your appointment without notification, your credit card will be charged \$25.
  - Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and "no-shows."
  - We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule with adequate advance notice, it is more likely that another patient in need will be able to use your time-slot. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need.

- New patient visits require our doctors to block out large time slots, making last-minute cancellations and rescheduling of visits even more problematic. We spend an inordinate amount of time and energy with each and every one of our new patients because we are committed to providing the highest quality care to be found anywhere. Again, please be aware that when you cancel or reschedule at the last-minute you are depriving care to another patient in need.
- Phone Consultations:
  - We bill for phone consultations. They require the same time and expertise as office visits.
  - Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to answer a question about your treatment protocol. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely your doctor will bill for the phone consultation.
- There are no refunds on any labs or services.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card if any of the above stipulations apply to you.

Name of Patient or Legal Guardian: \_\_\_\_\_

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

Type of Card: Visa MC Card Number: \_\_\_\_\_

Expiration: \_\_\_\_\_ Security Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

## Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture, Chinese medicinal herbs and Oriental medicine by a Licensed Acupuncturist at Hidden Rhythm Acupuncture. I understand that acupuncturists practicing in the state of Arizona are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended.

**Initial here \_\_\_\_\_ Acupuncture / Moxibustion:** I understand that acupuncture is performed by the insertion of single use sterile needles through the skin, application of low intensity laser light on the skin or by the application of heat to the skin at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. Acupuncture and Moxibustion are typically safe methods of treatment, however certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, dizziness, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop the acupuncture treatment at any time.

**Initial here \_\_\_\_\_ Pregnancy:** I will notify the acupuncturist should I become pregnant or if I am in the process of trying to become pregnant so that my practitioner can avoid points and herbs that could induce miscarriage. Otherwise, Chinese medicine treatment can be very beneficial in the pregnancy and birthing process.

**Initial here \_\_\_\_\_ Cold Laser Therapy:** I understand that I may be given laser therapy treatments that consist of low intensity laser exposure at various points on the body or head with the intention of stimulating or accelerating the healing process and reducing pain. I understand that while studies show overwhelming evidence towards the effectiveness of laser therapy, it is still considered "experimental" and that no guarantees are given regarding the results.

**Initial here \_\_\_\_\_ Acupressure / Tui-Na Massage:** I understand that I may also be given acupressure / tui-na massage as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

**Initial here \_\_\_\_\_ Cupping / Gua Sha:** I understand that I may also be given cupping (the application of glass cups with vacuum to the skin) and Gua Sha (rubbing of the skin with a smooth object such as a porcelain spoon) as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. ***I am aware that these treatments are intended to cause minor bruising and though unsightly are not normally painful.*** However certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse the treatment or stop the treatment at anytime for any reason.

**Initial here \_\_\_\_\_ Electro-Acupuncture:** I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I do not expect Craig Amrine or Hidden Rhythm Acupuncture staff to be able to anticipate and explain all possible risks and complications of treatment. I have carefully read and understand all the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation of anything regarding my treatment. I understand that my records will be kept confidential and will not be released without my written consent (unless in an emergency or by legal demand). I give my permission and consent to treatment.

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

\_\_\_\_\_  
**Printed Name:**

\_\_\_\_\_  
**Date of Birth:**

**Confidentiality Statement**

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your rights from the website at <http://www.hhs.gov/ocr/hipaa/> or by calling 1-866-627-7748.

You have the right to:

- • •
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Ask to see and get a copy of your health records. Have corrections added to your health information. Receive a notice that tells you how your health information may be used or shared. Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing. Request where you would like to be contacted. Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your doctor. •File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose any relevant information.

You are authorized to discuss my personal medical information with the following people:

1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Name of Patient or Legal Guardian: \_\_\_\_\_

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

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<p><b>Cardiovascular</b></p> <p><b>Conditions:</b></p> <input type="checkbox"/> Heart Disease <input type="checkbox"/> A Pacemaker <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Stroke <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Edema	<p><b>Emotional / Mental:</b></p> <input type="checkbox"/> Clinical Depression <input type="checkbox"/> Mild Depression <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Mood Swings <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia	<p><b>Energy &amp; Immunity:</b></p> <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> General Fatigue <input type="checkbox"/> Slow Wound Healing <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Chronic Infections <input type="checkbox"/> Frequent Allergies	<p><b>Respiratory:</b></p> <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Frequent Common Colds <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Emphysema <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Pleurisy <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Shortness of Breath
<p><b>Musculo-Skeletal:</b></p> <input type="checkbox"/> Neck / Shoulder Pain <input type="checkbox"/> Muscle Spasms / Cramps <input type="checkbox"/> Arm Pain <input type="checkbox"/> Upper Back Pain <input type="checkbox"/> Mid Back Pain <input type="checkbox"/> Low Back Pain <input type="checkbox"/> Leg Pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Joint Pain	<p><b>Head, Eye, Ear, Nose &amp; Throat:</b></p> <input type="checkbox"/> Impaired Vision <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Glaucoma <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Tearing / Dryness <input type="checkbox"/> Impaired Hearing <input type="checkbox"/> Ear Ringing <input type="checkbox"/> Earaches <input type="checkbox"/> Ear Infections <input type="checkbox"/> Headaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Teeth Grinding <input type="checkbox"/> Frequent Sore Throats <input type="checkbox"/> TMJ / Jaw Problems <input type="checkbox"/> Hay Fever	<p><b>Genito-Urinary Tract:</b></p> <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Painful Urination <input type="checkbox"/> Dribbling Urination <input type="checkbox"/> Frequent UTI <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Discharge <input type="checkbox"/> Incontinence <p><b>Neurological:</b></p> <input type="checkbox"/> Vertigo / Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Seizures / Epilepsy <input type="checkbox"/> Dyslexia	<p><b>Gastrointestinal:</b></p> <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Changes in Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Epigastric / Abdominal Pain <input type="checkbox"/> Passing Gas <input type="checkbox"/> Heart Burn <input type="checkbox"/> Belching <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Gall Bladder Stones <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea
<p><b>Endocrine:</b></p> <input type="checkbox"/> Hypothyroid <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperthyroid <input type="checkbox"/> Diabetes Type I <input type="checkbox"/> Diabetes Type II <input type="checkbox"/> Night Sweats <input type="checkbox"/> Unusual Sweating <input type="checkbox"/> Feeling Hot or Cold	<p><b>Other:</b></p> <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Lupus <input type="checkbox"/> Candida <input type="checkbox"/> Anemia <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema / Hives <input type="checkbox"/> Cold Hand / Feet <input type="checkbox"/> Hemophilia <input type="checkbox"/> Thin / Graying hair	<p><b>Liver Conditions:</b></p> <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C	<p><b>Men Only:</b></p> <input type="checkbox"/> Impotence <input type="checkbox"/> Vasectomy Date: _____ <input type="checkbox"/> Prostate problems <input type="checkbox"/> Testicular Pain / Redness / Swelling <input type="checkbox"/> Low libido <input type="checkbox"/> Excessive libido <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Seminal emissions

**Women Only:**

Are you pregnant right now?  Yes  No  Trying  Maybe Method of Birth

Control: \_\_\_\_\_

Age at first period: \_\_\_\_\_ Date of last menses: \_\_\_\_\_ Age at menopause: \_\_\_\_\_

Typical length of menses (days): \_\_\_\_\_ Typical length of cycle (from 1<sup>st</sup> day to 1<sup>st</sup> day of menses): \_\_\_\_\_

Number of: Pregnancies: \_\_\_\_\_ Births: \_\_\_\_\_ Abortions: \_\_\_\_\_ Miscarriages: \_\_\_\_\_

Hysterectomy:  Yes  No Date: \_\_\_\_\_

*Check all that apply:*  Low libido  Excessive libido  Painful Intercourse  Clotting  Painful Periods

Heavy Flow  Scanty Flow  Bleeding Between Cycles  Irregular Cycles  Vaginal Discharge  Breast

Lumps / Tenderness  Nipple Discharge  Infertility  Menopausal Symptoms  Premenstrual Problems