Patient Insurance Form

Please take the time to call your Insurance company and fill out the information below. It is important to take down the Name/Reference # for the call as we can hold them responsible for quoted benefits. If there is something you don't understand about your benefits, please call Rachel (our insurance guru) at 541-550-8541 for explanation or help. Thank you!

****

Patient Name: _____DOB: _____ Date: _____

Insurance Co: _____ ID #: _____ Group #: _____

Phone #: _____Spoke with: _____ Reference #:_____

Acupuncture coverage? Y / N COMBO? Y / N with what? _____

Calendar year or PLAN year:_____ renewal date?_____

Deductible? _____ how much used? _____

Copay / Co Insurance? _____MAX benefits?_____ used? _____

Is an AUTHORIZATION needed? Y / N

EXCLUSIONS:_____

Notes:_____

Informed Consent to Treatment for Randy Weinreb, LMT, L.Ac. & Megan Carmichael LAc

Oriental Medicine is an ancient form of healing that began in China over 3,000 years ago and is now utilized throughout the world. Diagnosis and treatment are based on the premise that our bodies use bioelectrical energy called Qi ("chee") that runs through our systems in organized energy flows called meridians. This energy can be affected by both internal and external factors, such as extreme emotions, seasonal and environmental changes, or trauma, and these factors can create imbalances in the system that can lead to physical and psychological manifestations. Oriental Medicine takes into account the incredible complexity of each individual's mind, body, and spirit. The goal of treatment is to rebalance the energetic systems, optimizing a person's function on all levels.

Oriental medicine is a proven, safe, and effective form of treatment for a wide variety of conditions and can work well in conjunction with any other medical treatment with no side effects. The primary modality used in Oriental Medicine is acupuncture, the insertion of thin, sterile, single-use disposable needles, in the body. Various sensations are experienced during treatment including a distended feeling around the needle site, itching, tingling, a dull ache, or energy moving. Some patients feel nothing until after the treatment. If at any time you experience a stinging, burning or any uncomfortable feeling, please let your practitioner know so that the needle may be adjusted or removed. After the needles are in place you will be given time to rest, usually 20-45 minutes. During this time many experience a floating or heavy sensation, but most patients typically feel comfortable, relaxed and sometimes fall asleep. It is advisable to avoid heavy exercise, eating, alcohol, or stimulants just before or after treatments. Please inform your acupuncturist if you have any food or drug allergies, if you are pregnant, or if you are wearing a pacemaker.

Inherent risks of acupuncture treatment include and are not limited to slight bruising and dizziness. It is possible to experience changes in emotion, appetite, sleep, energy levels, and bowel or urinary patterns. If you have any concerns, do not hesitate to call. Randy's cell phone number is (541) 306-7842. In a medical emergency contact your physician or nearest medical facility.

Cancellation Policy: please give at least 24 hours notice if you need to reschedule so that the time may be used for someone else.

I, (patient's name)_____do hereby request and consent to the performance of procedures that are within the scope of Acupuncture and Oriental Medicine as recognized by the state of Oregon, including but not limited to: acupuncture, moxibustion, cupping, electro-acupuncture, herbal therapy, nutritional consultation, and infra-red heat therapy on me (or the patient for whom I'm legally responsible), by the acupuncturist named above and or other licensed acupuncturists who now or in the future work with or serve as back-up for the acupuncturist named above. I have the choice at any time to accept or reject any procedure being offered, and understand that the results are not guaranteed. This consent is

intended to cover the entire course of treatment for any present conditions and for any future conditions for which I seek treatment. I am responsible for all payments of my treatments at the time of service. Randy Weinreb, LMT, L.Ac. is a private practitioner and all issues regarding treatment or payment will be addressed to him. My signature below signifies that I have read and understand all of the above, all privacy practices, and I give my consent to treatment.

Name_____Date_____, the undersigned, have received and understand the above NOTICE.

Patient Signature Printed Patient Name Date

HIPAA

Effective Date: April 14 , 2003

Notice Patient Privacy

(Short Form)

Health Insurance Portability and Accountability Act (HIPAA)

Simply Acupuncture is dedicated to preserving your "Protected Health Information" (PHI). We are required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and Simply Acupuncture's duties with respect to your protected health information. Simply Acupuncture may use or disclose your PHI for the purpose of diagnosing or providing treatment, obtaining payment for health care bills or to conduct health care operations. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. Your PHI means health information, including your demographic information, collected by other health care providers, a health care clearinghouse, an employer, or us. This protected health information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of disclosures of your medical information, requesting that we communicate with you confidentially, request that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated. All requests and complaints must be made in writing.

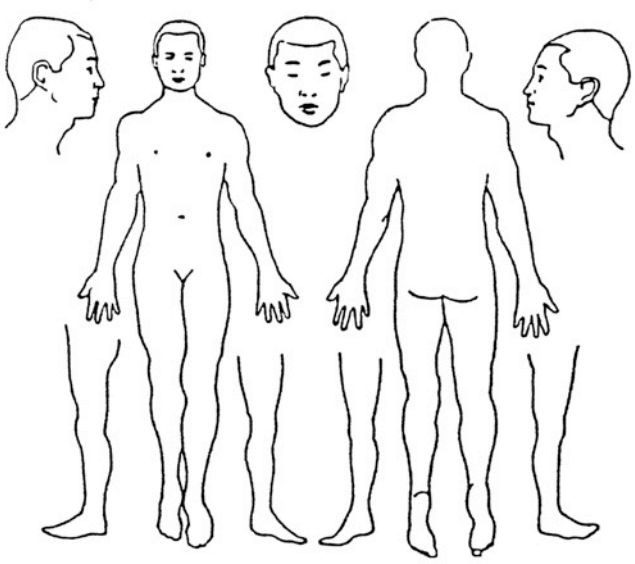
HIPPA has been read. Please initial here: _____

Health History Questionnaire

Please help us provide you with a complete evaluation by taking the time to fill out this Questionnaire carefully. All of your answers will be held absolutely confidential. If you have questions, please ask. Thank you.

Date_____ Name _____
Sex M F Age_____ Birth date_____
Address_____
City _____State_____Zip_____
Home Phone _____Alternate Phone_____
Email address:_____
Occupation _____How Long_____
Company Name and Address_____
Marital Status _____Spouse's First Name_____
Address (if different than above)_____
In Emergency Notify_____Phone _____
Family Physician_____
Who referred you to this office?_____
Date symptoms first noticed_____
Is your condition due to an accident YES NO work related? YES NO

What are the main problems you would like us to help you with?
_____



How long ago did these problems begin (be specific)?_____
To what extent do these problems interfere with your daily activities (work, sleep, sex, etc.)?
_____

Have you been given a diagnosis for these problems? YES NO
Diagnosis:_____
What kind of treatment have you tried?_____

PAST MEDICAL HISTORY (please circle and include date):
Significant diseases:

Cancer	Diabetes	Heart Disease	Rheumatic Fever
Thyroid Disease	Seizures	Venereal Disease	Hepatitis
High Blood Pressure		Other	

Surgeries:_____
Significant Trauma (auto accident, falls, etc.):_____
_____
Allergies (drugs, chemicals, foods, oils):
FAMILY MEDICAL HISTORY

Diabetes	Cancer	High Blood Pressure	Seizures
Asthma	Allergies	Heart Disease	Stroke

OCCUPATION
Occupational Stress (chemical, physical, psychological, etc.)

Do you have a regular exercise program? Please describe.

MEDICINES taken within the last two months
(Include vitamins, over-the-counter drugs, herbs, etc.)

Are you or have you ever been on a restricted diet? What kind?

Please describe your average daily diet:
Morning Afternoon Evening
HABITS:

Cigarettes	Coffee	Tea	Cola	Alcohol
Drugs	Sugar	Salt	Other_____	

Indicate painful or distressed areas on the diagrams below:
Please indicate your pain level from 1 – 10 (10 being the worst).
Additionally, please indicate:

N = Numbness	T = Tingling	A = Aching	S = Stabbing	CR = Cramping
C = Constant	I = Intermittent	O = Occasionally		

Is there anything that makes the pain better or worse:
Is the pain better with heat? Yes No
Is the pain better with cold? Yes No

Please circle if you have had any of the following in the last three months.

GENERAL

Poor Appetite	Poor Sleeping	Fatigue
Fevers	Chills	Night Sweats
Sweat easily	Tremors	Cravings
Localized weakness	Poor balance	Change in appetite
Peculiar tastes	Peculiar smells	Strong thirst (cold or hot drinks)

Sudden energy drop (What time of day?) _____

SKIN AND HAIR

Rashes	Ulcerations	Hives
Itching	Eczema	Pimples
Dandruff	Loss of Hair	Recent moles

Change in hair or skin texture?_____

Any other hair or skin problems?_____

HEAD, EYES, EARS, NOSE, AND THROAT

Dizziness	Concussions	Migraines
Glasses	Eye strain	Eye pain
Poor vision	Night blindness	Color blindness
Cataracts	Blurry vision	Earaches
Ringing in ears	Poor hearing	Spots in front of eyes
Sinus problems	Nosebleeds	Recurrent sore throats
Grinding teeth	Facial pain	Sores on lips or tongue
Teeth problems	Jaw clicks	

Headaches (Where and When?)_____

Any other head or neck problems?_____

CARDIOVASCULAR

High blood pressure	Low blood pressure	Chest pain
Irregular heartbeat	Dizziness	Fainting
Cold hands or feet	Swelling of hands	Swelling of feet
Blood clots	Phlebitis	Difficulty in breathing

Any other heart or blood vessel problems?_____

RESPIRATORY

Cough	Coughing blood	Asthma
Bronchitis	Pneumonia	Pain with a deep breath
Difficulty in breathing when lying down		
Production of phlegm?		What color?

Any other lung problems?_____

GASTROINTESTINAL

Nausea	Vomiting	Diarrhea
Constipation	Gas	Belching
Black stools	Blood in stools	Indigestion
Bad breath	Rectal pain	Hemorrhoids
Abdominal pain or cramps		Chronic laxative use

Any other problems with your stomach or intestines?_____

GENITO-URINARY

Pain on urination	Frequent urination	Blood in urine
Urgency to urinate	Unable to hold urine	Kidney stones
Decrease in flow	Impotency	Sores on genitals
Do you wake up to urinate?	How often?	
Any particular color to your urine? (normal color is straw color)		

Any other problems with your genital or urinary system?_____

MUSCULOSKELETAL

Neck pain	Muscle pain	Knee pain
Back pain	Muscle weakness	Foot/ankle pain
Hand/wrist pain	Shoulder pain	Hip pain

Any other joint or bone problems?_____

PREGNANCY AND GYNECOLOGY

Number of pregnancies	Number of births	Premature births
Miscarriages	Abortions	Age at first menses
Painful periods	Clots	Irregular periods
Vaginal discharge	Vaginal sores	Breast lumps
# of days between periods	# of days from first to last day of bleeding	
Unusual character (heavy or light)?		If heavy, how many days?
Date of last menses:	Last PAP	
Changes in body/psyche prior to menstruation?		
Do you practice birth control?		What type and for how long?

NEUROPSYCHOLOGICAL

Seizures	Dizziness	Loss of balance
Areas of numbness	Lack of coordination	Poor memory
Concussion	Depression	Anxiety
Bad temper	Easily susceptible to stress	

Have you ever been treated for emotional problems?

Have you ever considered or attempted suicide?

Any other neurological or psychological problems?_____