WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Acupuncture Intake Form

Name _____ Gender _____ Date_____

Address _____City_____ State_____ Zip_____

Home Phone _____Cell Phone_____ Date of Birth _____ Age_____

Email: _____ Occupation: _____

How did you hear about us? _____. If you are 65 or older: Medicare or SSN: _____

Would you like to pay with: Insurance (please give front desk your card) OR out of pocket (Circle one).
Is this an Auto Accident or Work Comp related injury? (circle): Insurance/claim #: _____
Date of Accident or injury: _____

Have you received Acupuncture treatment before? YES ___ NO ___

Do you bruise easily? YES ___ NO ____

Are you pregnant? YES ____ NO ____ N/A _____

Please mark if you have any of the following: PACEMAKER ____ INSULIN PUMP ____ BLEEDING DISORDER ____
ELECTRONIC DEVICE IMPLANTED IN BODY _____ SEIZURE DISORDER _____

SURGERIES / HOSPITALIZATIONS (Please include Reason, Month & Year)

1. _____
2. _____
3. _____

HEIGHT: _____ **WEIGHT**: _____ **WEIGHT CHANGE IN PAST YEAR** (GAIN /LOSS AMOUNT): _____

REASON (S) FOR SEEKING CARE:

Primary concern: _____

Secondary concern: _____

Other concern: _____

Are you presently under a doctor's care for this complaint? YES ____ NO ____

Doctors/Clinic name: _____

YOUR CURRENT PAIN EXPERIENCE:

Where is the pain today? _____

When did this recent concern begin? _____

How did your pain begin? _____

Singular event or trauma? YES ___ NO ____

Have you had this pain before? YES ____ NO ____ If Yes, when: _____

How often does this bother you?

Daily _____ Weekly _____ Monthly _____ Other _____

How long does it last?

Seconds _____ Minutes _____ Hours _____ Other _____

Please check the quality of the complaint/pain:

Tight ___ Sore ____ Dull ___ Achy ____ Numb ____ Sharp ____ Tingling ____ Throbbing ____

Pinching ____ Pressure ____ Stabbing ____ Electrical ____ Radiating ____ Other _____

Circle: Pain Intensity at **WORST** (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst pain imaginable)

Circle: Pain Intensity on **AVERAGE** (0 = No pain) 0 1 2 3 4 5 6 7 8 9 10 (10 = Worst pain imaginable)

Please check what makes the pain **BETTER**:

HEAT ____ COLD ____ REST ____ ACTIVITY ____ MASSAGE ____ SITTING ____ STANDING ____

LAYING DOWN ____ DRIVING ____ WORK _____ STRESS _____ OTHER _____

Please check what make the pain **WORSE**:

HEAT _____ COLD ____ REST ____ ACTIVITY ____ MASSAGE ____ SITTING _____ STANDING _____

LAYING DOWN ____ DRIVING ____ WORK _____ STRESS ____ OTHER _____

Please mark if your pain interferes with: WORK ___ HOME ___ EXERCISE ___ MOBILITY ___ EATING___

DRESSING ____ BATHING ____ USING THE TOILET ____ SLEEP ____

CURRENT pain interventions: treatments, medications, surgery, or care you've sought for this pain:

_____

PREVIOUS pain interventions: treatments, medications, surgery, or care you've sought for this pain:

_____

CURRENT / PAST HEALTH HISTORY: Mark **"C"** for Current or **"P"** for Past

DO YOU CONSUME THE FOLLOWING:

Cigarettes or Tobacco: _____ Packs per Day: _____ Packs per Week: _____

Alcohol: _____ Drinks per Day: _____ Times per Week: _____

Marijuana: _____ Times per Day: _____ Times per Week: _____

Other Recreational Drugs / non prescribed: _____ Times per Day: _____

RATE YOUR STRESS LEVEL ON A SCALE OF 1 – 10 (0 = LOWEST, 10 HIGHEST): _____

ACUPUNCTURE NATURE OF TREATMENT

Your treatment may include acupuncture, acupressure and/or Tui Na, moxibustion, cupping, Gua Sha, electrical stimulation, infrared heat, Chinese herbal therapy, therapeutic exercises, and dietary counseling based on the fundamentals of Chinese Medicine.

- **ACUPUNCTURE:** Acupuncture as practiced in the state of Oregon involves the insertion of sterile, single-use disposable needles into the body at various points eliciting a therapeutic effect. It has been shown to be relatively safe with little to no side-effects for most people. There are some uncommon potential risks however. These risks may include but are not limited to: discomfort during and after needle insertion, localized minor bruising or swelling, dizziness, fainting or nausea, allergic reactions to metals used in acupuncture needles, organ puncture, and nerve damage.

- **ACUPRESSURE AND TUIN NA:** These methods of massage and physical manipulation utilize the points and channels of Chinese medical theory to treat the body without the use of needles. They can be used as an adjunctive therapy to acupuncture, or as stand-alone treatments according to the patient's needs.

- **MOXIBUSTION:** This treatment method involves the combustion of the therapeutic herb Artemisia Argyi, commonly known as Mugwort, either directly or on over various points of the body. This therapy produces warmth and heat in the area of application, and exhibits other therapeutic effects attributed to the herb as described in the Chinese Materia Medica. Burns and/or scarring are potential risks of moxibustion.

- **CUPPING:** Fire is used to create a vacuum inside sterilized glass cups that are then placed on the patient's skin. This vacuum has a mild to strong suctioning effect, depending on the nature of the treatment as determined by the acupuncturist. Silicone or suction type cups may be used in lieu of fire cups as determined by the acupuncturist. The most common side effects are reddening of the skin that may last for a few days to a week and bruising.

- **GUA SHA:** Gua Sha is a form of dermal friction whereby a sterilized tool is used to scrape along the surface of the skin. In Chinese medical theory, it has a wide range of therapeutic uses. The most common side effects are reddening of the skin that may last for a few days and bruising.

- **ELECTRICAL STIMULATION:** Pairs of acupuncture needles are attached to a device that generates continuous electric pulses using small clips. These devices are used to adjust the frequency and intensity of the impulse being delivered, depending on the condition being treated. Please inform your acupuncturist if you have any implanted medical devices.

- **INFRARED HEAT:** A far-infrared heat lamp may be utilized during treatment to either enhance the treatment or for the comfort of the patient. Please inform your acupuncturist if you have any conditions that are exacerbated by the direct application of heat.

- **CHINESE HERBS:** Patients may be prescribed Chinese herbs as part of their treatment plan. Prescriptions generally consist of a combination of several herbs into a customized formula according to the patient's signs, symptoms, and overall constitution. The herbs that are recommended are traditionally considered safe in the practice of Chinese medicine within their prescribed dosages and methods of administration. Some possible side effects of taking herbs are nausea, gas, upset stomach, diarrhea, and tingling of the tongue. Patients must be sure to inform the acupuncturist of all the medications and supplements they are currently taking, as well as any known allergies.

- **THERAPEUTIC EXERCISES:** These include stretches, light exercise, meditation, and breathing exercises that the patient may be asked to perform at home.

SPECIAL SITUATIONS: Some herbs and acupuncture points are contraindicated during pregnancy. Please notify the acupuncturist if you think you might be pregnant. Additionally, please inform us if you have severe bleeding disorders, if you are wearing a pacemaker or other electronic medical device, and if you have any known allergies to foods or medications.

USE OF DISPOSABLE NEEDLES: All needles are pre-sterilized, single-use needles made of surgical stainless steel. After treatment they are disposed of as medical waste: needles are never re-used. Very rarely, the acupuncturist may accidently overlook a needle when removing them at the end of a treatment. If you find that you have a needle with you after you leave the office, do not me alarmed. Simply remove the needle, place in a hard container, and return it to the office on your next visit for proper disposal.

OUTCOME OF TREATMENT: The purpose of treatment is to resolve your complaint, i.e. the reason you are seeking treatment. Acupuncture is a health care service that is based on the pre-scientific Chinese system of medical theory. Diagnosis and treatment based on this theory are used to promote health and treat organic or functional disorders. This medical system utilizes a holistic approach, thereby treating the entire person and not singular symptoms. You may experience changes in your physical, mental, or emotional health that may seem unrelated to your complaint. If you have any questions or concerns regarding any changes or new symptoms that arise during the course of treatment, please inform your acupuncturist.

The World Health Organization lists multiple diseases for which acupuncture and its adjunctive therapies have been proved through controlled trials to be an effective treatment, as well as listing many more diseases for which acupuncture has been shown to have a therapeutic effect. However, we cannot guarantee the outcome of any course of treatment.

PATIENT NAME: _____

PATIENT SIGNATURE: **X** _____ Date: _____

(Or Patient Representative)

Indicate relationship if signing for patient:

ACUPUNCTURE INFORMED CONSENT TO TREAT

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding the care recommended, the benefits and risks associated with the care, alternatives, and the potential effect on my health if I choose not to receive the care. Acupuncture is not intended to substitute for diagnosis or treatment by medical doctors or to be used as an alternative to necessary medical care. It is expected that you are under the care of a primary care physician or medical specialist, that pregnant patients are being managed by an appropriate healthcare professional, and that patients seeking adjunctive cancer support are under the care of an oncologist.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the acupuncturist indicated below and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with, or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, acupressure, Tui-Na (Chinese massage), moxibustion, cupping, gua sha, electrical stimulation, infrared heat, Chinese herbal medicine, nutritional counseling, and therapeutic exercises. I understand that the herbs may need to be prepared and the teas 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 of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I appreciate that it is not possible to consider every possible complication to care. I have been informed that acupuncture is a generally safe method of treatment, but, as with all types of healthcare interventions, there are some risks to care, including, but not limited to: bruising; numbness or tingling near the needling sites that may last a few days; and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although the clinic uses sterile disposable needles and maintains a clean and safe environment.

I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal, and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. I will notify a clinical staff member who is caring for me if I am, or become, pregnant or if I am nursing. Should I become pregnant, I will discontinue all herbs and supplements until I have consulted and received advice from my acupuncturist and/or obstetrician.

While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff

thinks at the time, based upon the facts then known, is in my best interest. I understand that, as with all healthcare approaches, results are not guaranteed, and there is no promise to cure.

I understand that I must inform, and continue to fully inform, this office of any medical history, family history, medications, and/or supplements being taken currently (prescription and over-the-counter). I understand the clinical and administrative staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

I understand that there are treatment options available for my condition other than acupuncture procedures. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, I understand that I have the right to a second opinion and to secure other options about my circumstances and healthcare as I see fit.

By voluntarily signing below, I confirm that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I agree with the current or future recommendations for care. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

PATIENT NAME: _____

ACUPUNCTURIST NAME: _____

PATIENT SIGNATURE: **X** _____ Date: _____

(Or Patient Representative)

Indicate relationship if signing for patient:

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Patient Authorization Form

I have had the **Notice of Privacy Practice** made available to me and have had the opportunity to review its contents prior to signing this authorization.

I authorize the use of my medical information according to the **Notice of Privacy Practice**.

I authorize the release of any medical information necessary to process my claim.

I authorize the following individual(s) (family, spouse, friends) access to information about my medical records and appointments at **Whitaker Wellness / Powell Valley Wellness**:

Name(s): _____

I authorize **Whitaker Wellness / Powell Valley Wellness** to send text message reminders about my appointments and to leave a message whenever they need additional information from me.

☐ Check box if you **Do Not** approve voicemails when we have questions.

☐ Check box if you **Do Not** want text message reminders.

☐ Check box if you **Do Not** want Email reminders.

I authorize payment of medical benefits to **Whitaker Wellness / Powell Valley Wellness**

I authorize the release of information to any other entity for which I have signed a release.

I authorize **Whitaker Wellness / Powell Valley Wellness** to release information to any entity that I personally instruct them to release information to.

We, at **Whitaker Wellness / Powell Valley Wellness**, will gladly bill your insurance company. However, the full responsibility for payment of all professional services belongs to you, the patient.

If you do not have insurance or choose not to use your insurance, we do offer a Time Of Service Discount (TOSD) here. The TOSD will give you set pricing on your treatments here. You can use the TOSD for chiropractic, massage, and/or primary care. Pricing is dependent on the services performed. Please ask the front desk for specific pricing.

In order to qualify for the TOSD you have pay for your services the day of visit. If you do not pay the same day you were seen then you do not qualify for the TOSD and must pay full pricing.

We reserve the right, at our sole discretion, to charge a no show/late cancellation fee of $50.00 per occurance for missed appointments or appointments canceled less than 24 hours of their scheduled time and date. This will be deducted from any reimbursements made to the patient. If you have a Card on file you authorization us to charge that card.

_____ _____

Patient Name Date

_____ _____

Patient Signature (Parent/Guardian Signature if minor) Parent Name (If Minor)

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

CREDIT CARD ON FILE AGREEMENT

Powell Valley Wellness has implemented a new credit card policy. We Kindly request our patients for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

This "Card-on-File" can also be used to make payments if you do not want to pay your entire bill at one time. We are happy to charge no interest payments every month until patient's account balance is paid in full. There will be a **minimum** payment amount based on money owed. Our **minimum** payments schedule is:

$1-$50 = must be paid in full. Does not qualify for payment plan.

$51-$100 = $20/month payment

$101-$500 = $50/month payment.

Greater then $500 = $100/month payment.

By signing below, I authorize Powell Valley Wellness to keep my signature and my credit card information securely on-file in my account. I authorize Powell Valley Wellness to charge my credit card for any outstanding balances when due.

Visa □ MasterCard □ Discover □ American Express □

Name on Card (Print): _____

Cardholder Relationship to Patient: _____

Credit Card Number: _____ Exp. Date: ___/____ CVV # (3 digits)____

Credit Card Holder's Signature: _____Date: _____

WHITAKER WELLNESS, LLC POWELL VALLEY WELLNESS

Cancellation Policy/No Show Policy for Doctor Appointments

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "Full" appointment book.

If any appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee each time; this will not be covered by your insurance company.

_____ _____

Patient name Date

_____

Signature Patient/Guardian