New Patient Acupuncture Intake Form

Patient Information:

Legal Name_____ Today's date _____ /_____ /_____

Preferred Name _____ Date of Birth _____ /_____ /_____ Age _____

Address_____ City _____ State _____ Zip _____

Email _____ Best contact Phone # (_____)_____-_____

Emergency Contact _____ Relationship _____ Phone (_____)_____-_____

Primary Care Provider (MD/ND) _____ Phone (_____)_____-_____

How did you hear about us? _____

Insurance & Payment for Care:

☐ Commercial health insurance ☐ Self ☐ MVA/Car insurance ☐ Workers Compensation

Insured Name (On Card): _____ Insured Date of Birth: _____

Insurance Name: _____ Phone: _____

Send Claims to Address: _____

ID/Policy #: _____Group #: _____

Secondary Insurance?: ☐Yes ☐No (If yes, we will ask for your secondary insurance info.)

Health Information:

What is the primary reason for your visit today? _____

How long has this been a problem? _____

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

Please list any other health concerns you would like to address during your visit:

1. _____ 2. _____ 3. _____

What are your treatment goals and expectations? _____

_____

Please list (with approx. dates) any serious illnesses, injuries, or hospitalizations: _____

_____

Please list any medications, supplements you are currently taking: _____

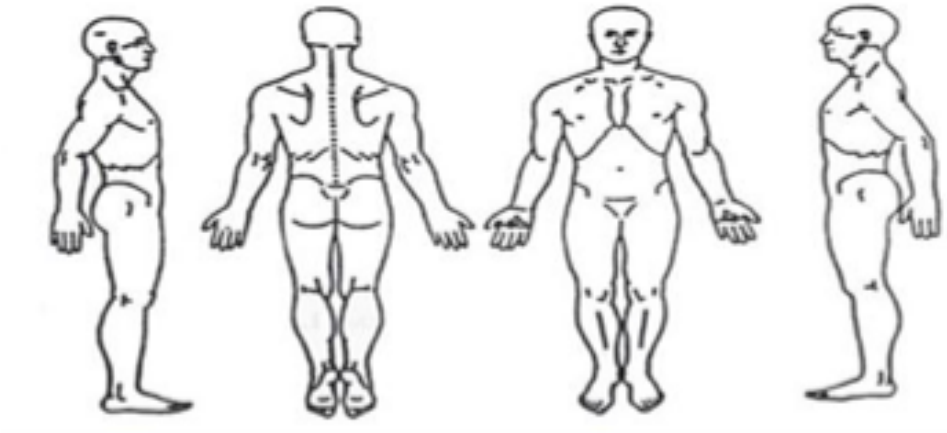
_____

Please list any allergies (drugs, chemicals, food): _____

_____

SHOW ALL AREA(S) OF PAIN OR DISCOMFORT Mark the areas on the figures below, using the appropriate symbols, where you feel the described sensations. Mark areas of radiating pain. Include all affected areas.

Numbness	Pins & Needles	Stiffness	Burning	Aching	Stabbing
•••	000	sss	xxx	>>>	////



On a scale of zero to ten, I rate my discomfort as follows: _____
(0=no discomfort 10=severe-unable to preform daily tasks) 0 5 10

Diet and Lifestyle:

Do you have a regular exercise program? If so, please describe: _____

_____

Do you have any dietary restrictions?_____

Please describe a typical day: Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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

_____

What do you do for fun? _____

How many hours of sleep do you get on an average night? ____Difficulty falling asleep? ☐ Y ☐ N Wake easily? ☐ Y ☐ N

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

Do you smoke cigarettes? ☐ Y ☐ N If yes, how often? _____

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week on average? _____

Do you drink caffeine? ☐ Y ☐ N If yes, in what form and how often? _____

Please describe any use of drugs for non-medical purposes:_____

Have you ever been treated for chemical dependency? ☐ Yes ☐ No

Men 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

Do you have a history of STI/STD? ☐Yes ☐ No

Are you currently experiencing symptoms? Please describe: _____

_____

Women Only

What was the date of your last period? _____ Age of first period: _____

If you are currently menopausal, are you experiencing symptoms? Please describe: _____

_____

Are you currently pregnant? ☐Y ☐ N If yes, how many weeks?_____

Total number of pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Have you experienced any of the following:

☐ Irregular cycle ☐ Painful cycle ☐ Missed period ☐ Menstrual cramps ☐ Ovarian cysts

☐ Breast tenderness ☐ Lumps in breasts ☐ Clotting ☐ Nipple Discharge ☐ Endometriosis

Average length of monthly cycle _____ # days of bleeding _____ Blood flow: ☐ heavy ☐ light ☐ normal

If you experience cramping, during which part of your cycle? ☐ before ☐ during ☐ after

Intensity of cramping 1-10 _____ Does anything provide relief? _____

Do you experience other changes in your body/psyche prior to menstruation (PMS symptoms)? Please describe:

_____

If you are currently using birth control? ☐ Yes ☐ No If Yes, What type and for how long? _____

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

Date of last Pap? (month/yr) _____/_____ Have you ever had an irregular Pap smear? ☐ Yes ☐ No

Do you have a history of STI/STD? ☐ Yes ☐ No

Are you currently experiencing symptoms? Please describe: _____

Do you experience bladder infections? ☐ Never ☐ Rarely ☐ Frequently

Do you experience vaginal infections? ☐ Never ☐ Rarely ☐ Frequently

Family Medical History (please specify family member):

☐ Cancer _____ ☐ Kidney Disease _____

☐ Heart Disease _____ ☐ Stroke _____

☐ High BP _____ ☐ Diabetes _____

☐ Alzheimer's _____ ☐ Arthritis _____

☐ Osteoporosis _____ ☐ Anxiety _____

☐ Depression _____ ☐ Mental Illness _____

Review of Systems (Please check all that apply):

General: ☐ *none of these*

☐ chills ☐ fatigue ☐ night sweats ☐ weight loss ☐ trouble sleeping ☐ fever ☐ weight gain

Eyes/Vision: ☐ *none of these*

☐ blindness ☐ change in vision ☐ redness ☐ photophobia(sensitivity to light) ☐ blurred vision ☐ double vision

☐ glaucoma ☐ flashing lights ☐ cataracts ☐ wear glasses/contacts ☐ itching ☐ eye pain

Ears, Nose and Throat: ☐ *none of these*

☐ bleeding	☐ ear drainage	☐ hearing loss	☐ nosebleeds	☐ sore throat	☐ dentures
☐ fainting	☐ rhinorrhea (runny nose)	☐ history of head injury	☐ difficulty swallowing	☐ tinnitus (ringing in ears)	☐ snoring
☐ ear pain	☐ hoarseness	☐ sinus infections	☐ postnasal drip	☐ TMJ problems	☐ nasal congestion
☐ discharge	☐ sore tongue	☐ loss of sense of smell	☐ dizziness	☐ headaches	☐ neck pain

Respiration: ☐ *none of these*

☐ asthma ☐ coughing up blood ☐ sputum production ☐ cough ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ *none of these*

☐ angina (chest pain or discomfort) ☐ shortness of breath with exertion or exercise ☐ waking at night w/ shortness of breath ☐ leg pain/ache

☐ tightness ☐ low blood pressure ☐ swelling of legs ☐ heart problems

☐ varicose veins ☐ heart murmur ☐ difficulty breathing lying down ☐ ulcers

☐ high blood pressure ☐ palpitations

Gastrointestinal: ☐ *none of these*

☐ abdominal pain ☐ diarrhea ☐ indigestion ☐ jaundice ☐ heartburn ☐ nausea

☐ hemorrhoids ☐ difficulty swallowing ☐ change in appetite ☐ change in bowel habits ☐ constipation ☐ rectal bleeding

Female: ☐ *none of these*

☐ birth control ☐ cramps ☐ irregular menstruation ☐ vaginal discharge ☐ pregnancy

☐ breast lumps/pain ☐ hormone therapy ☐ breast feeding

Urinary: ☐ *none of these*

☐ burning urination ☐ frequent urination ☐ blood in urine ☐ urgency ☐ incontinence

Endocrine: ☐ *none of these*

☐ cold intolerance ☐ excessive hunger ☐ sweating ☐ diabetes ☐ frequent urination ☐ unusual hair growth/ loss

☐ excessive thirst ☐ heat intolerance ☐ voice changes ☐ excessive appetite ☐ change in appetite

Skin: ☐ *none of these*

☐ changes in nail texture ☐ hair loss ☐ itching ☐ skin lesions / ulcers ☐ changes in skin color ☐ rash

☐ numbness/tingling ☐ hives ☐ dryness ☐ open wounds/cuts ☐ history of skin disorders/conditions

Neurologic: ☐ *none of these*

☐ dizziness ☐ limb weakness ☐ slurred speech ☐ numbness ☐ loss of consciousness ☐ unsteadiness of gait/ loss of balance

☐ headache ☐ seizures ☐ loss of memory ☐ strokes ☐ sleep disturbance

☐ stress ☐ tremor ☐ facial weakness ☐ fainting

Musculoskeletal: ☐ *none of these*

☐ stiffness ☐ redness of joints ☐ joint swelling ☐ trauma ☐ back pain ☐ muscle or joint pain

Allergy: ☐ *none of these*

☐ anaphalaxis ☐ itching ☐ nasal congestion ☐ rash ☐ food intolerance ☐ sneezing

Neck: ☐ *none of these*

☐ lumps ☐ pain ☐ stiffness ☐ swollen glands

Psychiatric: ☐ *none of these*

☐ stress ☐ nervousness ☐ depression ☐ memory loss

Hematologic: ☐ *none of these*

☐ anemia ☐ blood transfusion ☐ blood clotting ☐ bruising easily ☐ TB ☐ Hepatitis

☐ HIV ☐ lymph node swelling ☐ open skin ulcerations/ abrasions ☐ bleeding easily ☐ communicable diseases

Hillclimb Chiropractic Clinic
Acupuncture Informed Consent

1409 5th Ave | Seattle WA 98101| 206-624-3590 | www.hillclimbclinic.com

In accordance with WAC 246-82-120, we bring the following to your attention:

Practitioners' Qualifications:

Dave Smart, LAc. Northwest Institute of Acupuncture and Oriental Medicine- Masters of Acupuncture, 2001**.** WA DOH, license #AC00000780

Kelly Miller, LAc. . Bastyr University- Bachelors in Oriental Medicine and Masters of Acupuncture, 1999, WA DOH, license #AC00000626.

1. Scope of Practice: The scope of practice for an acupuncturist in the state of Washington includes but is not limited to, use of acupuncture needles to stimulate acupuncture points and meridians, dietary advice based on traditional Chinese medical theory. The scope of practice for an East Asian medicine practitioner in the state of Washington includes the following: Acupuncture, Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians, Moxibustion, Acupressure, Cupping, Dermal friction technique, Infra-red, Sonopuncture, Laserpuncture, Point injection therapy (aquapuncture), Dietary advice, herbal recommendation, health education based on East Asian medical theory, Qi gong, East Asian massage and Tui na, Superficial heat and cold therapies.

2. Side effects and risks may include, but are not limited to: Minor bruising or pain following treatment in insertion area, possible infection, needle sickness, pneumothorax (lung puncture), and broken needle. To reduce the possibility of infection, all needles are presterilized, one-time-use-only, made of surgical stainless steel.

3. Patients must inform the East Asian medicine practitioner if the patient is **pregnant,** has a severe **bleeding disorder, or pace maker** prior to any treatment**.**

In accordance with WAC 246-802-110: If you are affected by any of the following conditions, we are required to request that you consult with a physician and provide a written diagnosis from him/her, or have the physician call us: Cardiac conditions including uncontrolled hypertension, Acute abdominal symptoms, Acute undiagnosed, neurological changes, Unexplained weight loss or gain in excess of fifteen percent body weight within a three month period, Suspected fracture or dislocation; Suspected systemic infection; Any serious undiagnosed hemorrhagic (bleeding) disorder; and Acute respiratory distress without previous history or diagnosis.

With this knowledge, I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of practice of acupuncture. I understand that I am free to withdraw my consent and that I may stop treatment or any procedure at any time. I understand that my signature in this form indicates that I have read and understand the preceding information regarding my treatment. I hereby release all practitioners and Hillclimb Chiropractic Clinic from all liability in connection with these treatments.

_____

Name (Please print)

_____ _____

Signature of Patient or Person Legally Authorized to Give Consent Date

Hillclimb Chiropractic Clinic

Acupuncture Clinic Policies

If using insurance, please inquire as to rates. Wellness Massage or Wellness Acupuncture Rate is $95 for one hour treatment.

Insurance and payment

- When we bill insurance for an out-of-network massage it is likely the insurance company will reimburse the patient rather than the provider of the service. If this occurs, we will need full payment in the amount the insurance reimbursed. Co-pays are due at time of service.
- Any deductible or co-pay must be paid at time of service.
- Any insurance checks sent to your home by the insurance company must be brought to our office within 3 days. With a copy of the payment stub indicating which services were paid.
- If your insurance company is not responding to our claims in a timely manner (60 days) you will be asked to call and/or write them to assist with collections for services rendered.
- **If your insurance company deems that services are not medically necessary, you will be responsible for any unpaid balance- as permitted by our contract with your insurance company.**
- There is a $25 processing fee added to any account for any returned check.

First Time at the Clinic Policy

For all first time clients to the clinic payment for massage or acupuncture treatment is required beforehand. In addition, first time cash massage/acupuncture or out-of-state patients are required to provide a photo ID and completed intake form. If no photo ID is available, we reserve the right to refuse service.

Allergies & Cuts, Scratches or Other Breaks in Skin Policy

Please note massage lotions may contain trace amounts of almond/nut extracts, apricot and mango, avocado, coconut, etc. Upon request we have a nut-free gel for those with nut allergies. Please inform your therapist of any nut, fruit or vegetable allergies. For the safety of both client and practitioner, Hillclimb Chiropractic Clinic's policy is that massage practitioners wear Nitrile (non-latex) gloves if the practitioner has any cuts, scratches or other skin breaks on his or her hands or if the client has any cuts, scratches or other breaks in his or her skin in the areas covered in a massage treatment.

Early Arrival Policy

On occasion massage/acupuncture practitioners work out of the clinic alone. If you arrive early for an appointment and the door is locked, please wait at the door until your scheduled appointment time as your practitioner may be with another patient and unable to open the door. Also due to government regulations for all treatment facilities regarding patient privacy, we cannot allow patients to wait alone in the office to see the therapist while he or she is seeing another patient. We are very sorry for any inconvenience this may cause; we will do our best to keep you from having to wait.

Late Arrival Policy

Out of respect and consideration to your therapist and other customers, **please** plan accordingly and be on time. If you arrive late, your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your therapist will determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment actually given, **you will be responsible for the "full" session**.

CANCELLATION & RESCHEDULING POLICY: 24-hour advance notice REQUIRED or you will be charged $35.00 cancellation fee

- There is a $35 fee for no show appointments.
- If cancelled within less than 24-hour notice and we are unable to rebook the appointment you will be charged the $35 fee.
- Cancellation/Missed appointment fees cannot be billed to insurance carriers and is your financial responsibility.

I understand that the nature of massage therapy/bodywork is for the purpose of health improvement and relaxation. I have stated all known medical conditions and will inform and update my therapist of any changes to my medical health as necessary. I understand that my session will be immediately terminated due to any form of inappropriate behavior and I will be charged the full amount for that appointment. We are committed to professionalism and expect the same from our clients. We will not tolerate any inappropriate acts.

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

I have read and understand the above policy.

_____ Date _____

Signature

_____

Print Name

Hillclimb Chiropractic Clinic Consent for Use and Disclosure of Health Information (HIPAA)

Matt Brown-Ruegg, DC PS | 1409 5th Ave | Seattle WA 98101| 206-624-3590 | www.hillclimbclinic.com

Matt Brown-Ruegg, DC PS DBA Hillclimb Chiropractic Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Content: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and/or healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of our protected health information, and of other important matters about your protected health information. A copy of our privacy policy is available upon request and on our website. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

Our Notice of Privacy Practices is available in full on our website at http://www.hillclimbclinic.com/new-patients/. Also, you can request a copy of our Notice of Privacy Practices, including any revisions by calling/emailing: (206)624-3590 or info@hillclimbclinic.com

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the email address above. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if your revoke or decline this consent.

SIGNATURE

I, _____(Print Name), have had full opportunity to read and consider the contents of this Consent for and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT- AVAILABLE UPON REQUEST

HILLCLIMB
CHIROPRACTIC CLINIC

Matt Brown-Ruegg, DC PS | 1409 5th Ave | Seattle WA 98101| 206-624-3590 | info@hillclimbclinic.com|
www.hillclimbclinic.com

Patient Messaging Consent

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize Hillclimb Chiropractic Clinic to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or other communications. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I understand that standard text messaging rates may apply to any message. I consent to the receiving multiple messages per day from the automated outreach and messaging system, when necessary.

I understand I can opt out at any time by calling 206-624-3590 and asking to be removed from appointment reminders and other communication.

Patient Name: _____ Date: _____

Signature: _____

Example of a Text Reminder from Hillclimb:

Hello Tim, This is a reminder for your CHIROPRACTIC appointment tomorrow at 1:00PM. Please call 206-624-3590 with questions. Text STOP to opt-out.