BRADENTON COMMUNITY ACUPUNCTURE INTAKE

Today's Date:			PCP:		
PATIENT INFORMATION					
Last name: First:		Middle:		Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address:					
Social Security Number:	Home phone Number:	Cell phone Number:			
May we call/text? ○ Yes ○ No		May we leave a voicemail? ○ Yes ○ No			
Email address:					
Occupation:	Employer:	Employer phone no.:			
Referred to clinic by (or how did you hear about us?):					
Other family members seen here:					
INSURANCE INFORMATION (please give your insurance card to the receptionist)					
Person responsible for bill:	Birth date:	Address:	Phone Number:		
Is this person a patient here?	○ Yes ○ No	Does this patient have insurance coverage for acupuncture?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone number:		
Please indicate primary insurance:			| Other:		
Subscriber's name:	Subscriber's SSN:	Birth date:	Group Number:	Policy #:	Co-payment:
Patient's relationship to subscriber:					
IN CASE OF EMERGENCY					
Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:		

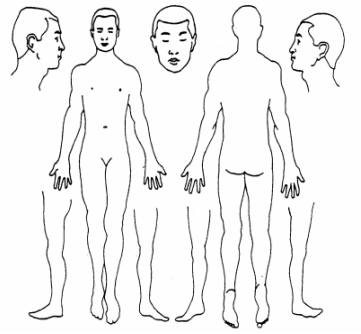
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize BCA or insurance company to release any information required to process my claim(s).

Signature Printed Name Date

PATIENT MEDICAL INFORMATION

Reason for visit today:

Please circle the area(s) of discomfort or pain on the diagram below:



How long have you suffered from this condition?	Is it getting worse?	Does it bother your work? Sleep? Other (please specify)?	Have you had acupuncture before? ◯ Yes ◯ No	Have you had Chinese Herbal Medicine before? ◯ Yes ◯ No

What seemed to be the initial cause?

What seems to make it better?	What seems to make it worse?	Are you under the care of a physician now? ◯ Yes ◯ No
Physician's name:	Physician's Phone Number:	Other concurrent therapies:

MEDICAL HISTORY

Your Past Medical History:

□ AIDs/HIV	□ Emphysema	□ Multiple Sclerosis	□ Tuberculosis	□ Other:
□ Alcoholism	□ Epilepsy	□ Pacemaker (Date)	□ Typhoid fever	
□ Allergies	□ Goiter	□ Pleurisy	□ Ulcers	
□ Appendicitis	□ Gout	□ Pneumonia	□ Venereal disease	
□ Arteriosclerosis	□ Heart Disease	□ Polio	□ Whooping cough	
□ Asthma	□ Hepatitis (Type:)	□ Rheumatic fever	□ Cancer (Please list type & treatment: _____)	
□ Birth Trauma	□ Herpes (Type:)	□ Scarlet fever	□ Major trauma (please specify_____)	
□ Chicken Pox	□ High Blood Pressure	□ Stroke	□ Seizures (please specify_____)	
□ Diabetes (Type:)	□ Measles/Mumps	□ Thyroid disorders	□ Surgeries (please list _____)	

Your Diet:

Appetite: □ Low: □ High

Protein Intake: □ Low: □ High

How many glasses of water per day? _____

Do you prefer salty or sweet foods? _____

Do you eat all organic? _____

Do you consume dairy? _____

Do you use artificial sweeteners? _____

Do you eat vegetables? How often? _____

Your Allergies:

Medicines/Supplements: Please list all your medicines and vitamins/supplements below, including dosage.

Family Medical History:

□ Allergies (list _____) □ Cancer (type _____) □ High Blood Pressure
□ Alcoholism □ Depression □ Seizures
□ Arteriosclerosis □ Diabetes (Type: ____) □ Stroke
□ Asthma □ Heart Disease □ Other:

Lifestyle:

Do you use:
□ Alcohol □ Marijuana □ Tobacco □ Other Drugs (please list: _____)

Do you exercise? How often? What type? _____
_____

On a scale of 1 – 100, how would you rate your stress level, on average: _____

General Symptoms:

□ Poor appetite □ Poor sleep □ Bodily heaviness □ Chills □ Bleed or bruise easily □ Heavy appetite □ Heavy sleep
□ Cold hands/ feet □ Night sweats □ Peculiar taste (_____) □Like cold drinks □ Dream-disturbed sleep □ Poor circulation □ Sweat easily
□ Like hot drinks □ Fatigue □ Shortness of breath □ Muscle cramps □ Weight loss/gain □ Lack of strength □ Fever
□ Vertigo/dizziness Other: _____

Head, Eyes, Ears, Nose, Throat:

□ Glasses (age____) □ Night blindness □ Gum problems □ Recurrent sore throat □ Headaches □ Eye strain □ Myopia/Presbyopia
□ Sores on lips/tongue □ Swollen glands □ Migraines □ Eye pain □ Glaucoma □ Dry mouth □ Lumps in throat
□ Concussions □ Red eyes □ Cataracts □ Excessive saliva □ Enlarged thyroid □ Itchy eyes □ Teeth problems
□ Sinus problems □ Nosebleeds □ Spots in eyes □ Grinding teeth □ Excessive phlegm □ Ringing in ears □ Poor vision
□ TMJ □ Poor hearing □ Blurred vision □ Facial pain □ Earaches □ Other: _____

Musculoskeletal:

□ Neck/shoulder pain □ Upper back pain □ Joint pain □ Limited range of motion □ Muscle pain □ Low back pain □ Rib pain □ Limited use
□ Other _____

Skin and Hair:

□ Rashes □ Eczema □ Dandruff □ Change in hair/skin texture □ Hives □ Psoriasis □ Itching □ Fungal infections □ Ulcerations
□ Acne □ Hair Loss □ Other: _____

Neuropsychological:

□ Seizures □ Poor memory □ Irritability □ Considered/attempted suicide □ Numbness □ Depression □ Easily stressed
□ Tics □ Anxiety □ Abuse survivor □ Currently seeing a therapist □ Other: _____

Respiratory:

□ Difficulty breathing when lying down □ Tight chest □ Cough (wet or dry? _____) □ Color of phlegm: _____ □ Coughing up blood lying down
□ Asthma/wheezing □ Pneumonia □ Shortness of Breath □ Difficult inhale? □ Other: _____

Cardiovascular:

□ High blood pressure □ Low blood pressure □ Chest pain □ Tachycardia □ Phlebitis □ Blood clots □ Fainting □ Difficulty breathing
□ Heart palpitations □ Irregular heartbeat/ Afib □ Other: _____

Gastrointestinal:

□ Nausea □ Diarrhea □ Intestinal pain/cramps □ Bowel movements: □ Vomiting □ Constipation □ Burning anus
□ Acid regurgitation □ Black stools □ Rectal pain *Frequency*_____ □ Gas □ Bloody stools □ Anal fissures
□ Hiccups □ Mucous in stools □ Laxative use *Color*_____ □ Bloating □ Hemorrhoid □ Bad breath
□ Itchy anus *Texture/form*_____
*Odor*_____

Genitourinary:

□ Pain on urination □ Blood in urine □ Venereal disease □ Increased libido □ Impotence □ Frequent urination □ Unable to hold urine
□ Bedwetting □ Decreased libido □ Premature ejaculation □ Urgent urination □ Incomplete urination □ Wake to urinate □ Kidney stones
□ Nocturnal emission □ Other: _____

Gynecology:				
□ Age menses began _____	□ Duration of flow _____	□ Vaginal discharge	□ Breast lumps	□ Date of last PAP _____
□ Date of last menstrual cycle _____	□ Color_____	□ Length of cycle _____	□ Irregular periods	□ Vaginal sores
□ # Pregnancies_____	□ # Live births_____	□ # Premature births____	□ Painful periods	□ Vaginal odor
□ PMS	□ Clots	□ Age at menopause_____		

Are you currently pregnant?	**Are you trying to become pregnant?**
○ Yes ○ No	○ Yes ○ No

Please Note: Your medical history will be kept in confidence. Information will not be released to anyone, except when you have authorized us to do so.

I have read and understood all of the questions on this form. My signature below confirms that I have answered each question truthfully and that I will inform *Bradenton Community Acupuncture* of any changes in my health care status.

_____ _____ _____

Patient Signature Patient Printed Name Date

I understand I will be assessed the full appointment fee (with a minimum of $25) for any appointment cancelled with less than 24 hours notice.

_____ _____ _____

Patient Signature Patient Printed Name Date

Bradenton Community Acupuncture Consent to Treat

I, _____ (printed name), hereby request and consent to the performance of acupuncture treatments, Traditional Chinese Herbal Medicine, and/or other procedures within the scope of the practice of acupuncture on myself (or on the patient named below, for whom I am legally responsible) by any acupuncturist within Bradenton Community Acupuncture who now, or in the future, will treat me while employed by, working or associated with or serving as back-up for Bradenton Community Acupuncture, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, nutritional counseling, botanical medicine, cosmetic acupuncture, JMT, homeopathy, gua sha, and acupuncture injection therapy.

I will immediately notify a member of the clinical staff of any unanticipated or unpleasant effects associated with any treatment performed, the consumption of the herbs, or any nutritional/botanical supplement. I have been informed that acupuncture and acupuncture injection therapy are generally safe methods of treatment, but that it may have some side effects, including 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 and injection therapy. Unusual risks of acupuncture include spontaneous miscarriage, 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, at all times. I understand that while this document describes the major risks of treatment, other side effects and risks may occur.

I understand that 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. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives and tingling of the tongue.

I will notify a clinical staff member who is caring for me if I am or become pregnant.

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 results are not guaranteed. 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.

By voluntarily signing below, I show 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 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 Signature*	Patient Printed Name	Date

*Indicate relationship if signing for patient

Bradenton Community Acupuncture Policy Regarding Financial Responsibility

Insurance: If your insurance is with a company with which we do not participate, you are responsible for the payment of your bill at the time of service. We will, however, upon request file non-assigned claims to the insurance companies as a courtesy to our patients – with the exception of the Medicare. For patients filing insurance, any of the following codes may be used:

99203 New Patient Office Exam
99213 Follow-Up Office Exam
97811 Acupuncture Reinsertion of Needles
97010 Heat Therapy
97810 Acupuncture
97814 Acupuncture Reinsertion w/E. Stim
97140 Manual Therapy
99070 Needles
97813 Acupuncture w/E. Stim
97032 E. Stim (attended)
97530 Kinetic Activities
97014 E. Stim (unattended)
97110 Therapeutic Activities
97026 Infrared

Self-Pay: All services are required to be paid in full at the time of service.

Fees: Please see "Fees" page.

Cancellations: We have a 24-hour cancellation policy. Failure to comply with this policy will result in the full service fee being charged (minimum of $25). Dismissal from this practice may occur after repeated offenses.

Summary: Providing quality medical care for our patients is our primary concern. We are more than willing to provide that care within the policies and guidelines of our patients' insurance plans. It is, however, the responsibility of the patient to know and understand those policies and guidelines**.** It is also the responsibility of patients to seek medical care only with physicians participating in their plans.

I, _____(printed name) understand that I am responsible for the payment of this account, and hereby assume and guarantee payment of all expenses incurred during my office visit. In the event a credit (refund) balance appears on this account, I hereby irrevocably authorize the office to transfer and apply such credit on any outstanding account with BCA incurred by myself, or my dependents. Should legal action be required to secure payment of this account, I agree to pay all collection expenses, all court costs and any attorney's fee incurred thereby. I authorize the release of any medical or other information necessary to the process of this claim. I also authorize payment of government benefits either to myself or to the party who accepts assignment in Box 27 of the CMS 1500 form on which claims for me are submitted. I understand that purchasing a treatment does NOT guarantee success in treatment.

_____ _____ _____

Patient Signature* Patient Printed Name Date

*Indicate relationship if signing for patient

Bradenton Community Acupuncture Fees

Bradenton Community Acupuncture provides high quality acupuncture treatment at affordable rates in a supportive community setting. Research in the United States (as well as thousands of years of tradition in Asia) has shown that acupuncture is most effective when it is done frequently and regularly – **once per week is usually the minimum required to make progress** on any kind of health problem.

Community Acupuncture Fees

The purpose of our sliding scale is to separate the issues of money and treatment. We want you to come in often enough to truly get better and stay better! We understand that everyone's situation is different **and *our primary goal is to make acupuncture available to you as often as you need it.***

Treatment Type	Cost
Community Room	Based on your income, we use a sliding scale of $25 - 65+ per treatment*
Individual Room	$85 per treatment*

**1st Treatment (only) please add $20 Consult fee to your session fee*

Note: Cupping, herbs, supplements, and Homeopathics will be charged extra.

Fertility Acupuncture Fees

Treatment Type	Cost
Individual Fertility Treatment	$85 per treatment*
1-Month Fertility Package Includes 1 treatment per week and limited text/email communication	$450*
3-Month Fertility Package (Most Popular) Includes your initial consult, 1 treatment per week and unlimited text/email communication with your Practitioner	$950
6-Month Fertility Package (Best Value) Includes your initial consult, 1 treatment per week and unlimited text/email communication with your Practitioner	$1400

**1st Treatment (for Individual & the 1-Month Package) please add $75 Consult Fee (first session only)*

Note: Cupping, herbs, supplements, and Homeopathics will be charged extra.

NOTE: We have a 24-hour cancellation policy. Failure to comply with this policy will result in the full service fee being charged (minimum of $25). Dismissal from this practice may occur after repeated offenses.

Bradenton Community Acupuncture Consent for Communication and/or Disclosure

Please indicate the number(s) you wish us to use to contact you:

Cell:_____ Home:_____ Work:_____

May we contact you:

On your **cell**? Yes No

If yes, may we leave the following information on your cell voicemail:

Appointment Information: Yes No
Billing Information: Yes No
Medical Information: Yes No

At **home**? Yes No

If yes, may we leave the following information on your home voicemail:

Appointment Information: Yes No
Billing Information: Yes No
Medical Information: Yes No

At **work**? Yes No

If yes, may we leave the following information on your work voicemail:

Appointment Information: Yes No
Billing Information: Yes No
Medical Information: Yes No

Please print the name(s) of family members or other persons whom we may inform about your general medical condition and/or your diagnosis (including treatment, payment and heath care operation):

_____ NONE

Name & Relationship_____Phone_____
Name & Relationship_____Phone_____
Name & Relationship_____Phone_____

Please who you would like us to contact ONLY IN CASE OF EMERGENCY:

Name & Relationship_____Phone_____

Please print the address where you wish billing statements and/or correspondence from our office to be sent.

_____ _____ _____ _____

Do you require that all correspondence from our office be marked "CONFIDENTIAL"? _____Yes _____No

May we send you email messages, such as newsletters and BCA updates, events and specials? ____Yes ____No

Email Address: _____

I request the above alternatives or limitations relating to communications directed to me by my healthcare provider or employee of Bradenton Community Acupuncture and give my permission to share the information as indicated with the person(s) named above.

_____ _____ _____

Patient Signature* Patient Printed Name Date

*Indicate relationship if signing for patient

What is different about the Bradenton Community Acupuncture?

❖ We Treat In a Community Setting

Most US acupuncturists treat patients on tables in individual cubicles. This is not traditional in Asia where acupuncture usually occurs in a community setting. In our clinic, we primarily use recliners in a quiet, soothing space. Treating patients in a community setting has many benefits: it's easy for friends and family to come in for treatment together, many patients find it comforting and a collective energetic field becomes established which makes individual treatments more powerful. Many people fall asleep and wake feeling refreshed!

❖ We Make Acupuncture Affordable

At BCA the we use a sliding scale for our community acupuncture and a significantly reduced fee structure for fertility acupuncture. This allows you to decide what you can afford and come in often enough to actually see improvement! As a reference, most US acupuncturists see only one patient per hour and charge $75 - $250+ per treatment. The way *BCA* can make acupuncture affordable and still make a living ourselves is to streamline our treatments and see multiple patients in an hour. As such, we have returned to the traditional approach; instead of asking you lots of questions, we rely on a few "to-the-point" questions and pulse diagnosis to decide how to treat you. This is exactly how acupuncture is traditionally practiced - multiple patients and very little talking.

What we need from you…

❖ Understanding

The community runs on a very tight schedule with chairs and tables being scheduled for **one hour at a time** per person. *Please understand if you arrive late for your appointment that your time in the chair or on the table will need to be shortened to accommodate the person whose turn it is next in the next hour.* As always, if there is no one scheduled for the chair or table after you, you are welcome to stay longer.

Twenty-four hour notice is REQUIRED for cancellations.

❖ Consideration

Please be considerate of people with allergies and sensitivities to perfumes and scents by refraining from wearing perfumes and scented shampoos, body washes, and soaps on days you are coming in for a treatment.

❖ Community-Mindedness

The soothing atmosphere in our clinic exists because all of our patients create it by relaxing together. We appreciate everyone's presence! This kind of collective stillness is a rare and precious thing in our rushed and busy society. Therefore – there are **no conversations in the treatment room** – only whispers if necessary!

❖ Commitment

Acupuncture is a **process**. It is very rare for any acupuncturist to be able to resolve a problem with one treatment. If you don't come in often enough or long enough, acupuncture probably won't work for you. The purpose of our sliding scale is to help you make that commitment.

❖ Referrals

One big reason that we are able to keep our prices so low is because of the extraordinary amount of marketing our patients do on our behalf -- we don't advertise. We cannot express how grateful we are for this. Our patients are such effective marketers because they have first-hand experience of how well acupuncture works. So please tell your friends about BCA!

And, last, but not least….enjoy the space! We do, and hope that Bradenton Community Acupuncture can become an important part of your life and community.