

INITIAL HEALTH STATUS

Acupuncture

For questions, please call ASH at 800.972.4226

Patient Name _____ Birthdate _____ Primary Language _____ Sex M / F

Last First

Address _____ City _____ State _____ Zip _____ Primary Phone _____

Employer _____ Occupation _____ Other Phone _____

Subscriber Name _____ Subscriber ID # _____ Group # _____

Primary Health Plan _____ Patient/Member ID # _____

2nd Health Plan _____ Primary Care Physician (PCP) _____ PCP Phone # _____
(Required) (Required)

Are you under the care of a physician? No Yes, for what conditions? _____

Please describe your current health problem(s) _____

How and When it began _____ Is this work related? Y / N

What treatment have you received for the above condition(s)? Surgery Medications Physical Therapy

Injections Chiropractic Massage Other _____

Please describe your progress: Worse No Change 25% Better 50% Better 75% Better or _____

Circle your current pain areas: Head, Neck, Jaw, Shoulder, Arm, Elbow, Hand, Wrist, Upper Back, Low Back, Tailbone, Hip, Thigh, Knee, Ankle, Foot, Chest, Abdomen, Other _____

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

In the past week, how much has your pain interfered with your daily activities?

No Interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

How often are your symptoms present? Constantly Frequently Intermittently Occasionally

Describe your current health condition: Excellent Very Good Good Fair Poor

Please check all of the following that apply to you and list any medication(s) you are taking:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcohol/Drug Dependence | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Abnormal Menstruation | <input type="checkbox"/> Headache | <input type="checkbox"/> Tobacco Use - Type _____
Frequency _____/Day |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heartburn or Indigestion | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis/
Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hospitalizations/Surgical
Procedures _____ | |
| <input type="checkbox"/> Asthma | | |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Kidney Disease | If a family member has had any of the following, please mark the appropriate box and explain the relationship:

<input type="checkbox"/> Cancer _____
<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Hypertension _____
<input type="checkbox"/> Lupus _____
<input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Breast Lumps | <input type="checkbox"/> Liver Problems | |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Palpitation/Arrhythmia | |
| <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Peptic Ulcer | |
| <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Pregnant, # Weeks _____ | |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Prostate Problems | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Weight Gain/Loss | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Sinusitis | |

Comments _____

I certify that the above information is complete and accurate to the best of my knowledge. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services. I agree to notify this provider immediately whenever I have changes in my health condition or health plan coverage. I understand that my provider of acupuncture services may need to contact my Primary Care Physician or treating physician if my condition needs to be co-managed. Therefore, I give authorization to my provider of acupuncture services to contact my medical doctor if necessary.

Patient signature _____ Date _____

Access Acupuncture, Inc.

24619 Washington Avenue
Suite 206
Murrieta, CA 92562
951.698.0102

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROVIDER FROM PRIVATE AND GROUP
ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ Insurance
Company to pay by check made out and mailed directly to:

Access Acupuncture
24619 Washington Avenue
Suite 206
Murrieta, CA 92562

If my current policy prohibits direct payment to provider, then I hereby also and instruct and direct you
to make out the check to me and Access Acupuncture and mail it to the above address.

For the professional or acupuncture expense benefits allowable, and otherwise payable to me under my
current insurance policy as payment toward the total charges for professional services rendered.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not
exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current
manner, any balance of said professional service charges over and above this insurance payment.

A photo copy of this Assignment shall be considered as effective and valid and the original.

I also authorize the release of any information pertinent to my case to any Insurance company, adjuster,
or attorney involved in this case.

Date _____

Signature of policyholder

Signature of Claimant, if other than Policyholder

Access Acupuncture
24619 Washington Ave. Ste. 206
Murrieta, CA 92562
951.698.0102

Privacy Policies

Dear Valued Patient,

This notice describes our office's policy for how medical information about you may be used and disclosed, how you can get access to this information, and how your privacy is being protected.

In order to maintain the level of service that you expect from our office, we may need to share limited personal medical and financial information with your insurance company, with Worker's Compensation (and your employer as well in this instance), or with other medical practitioners that you authorized.

Safeguards in place at our office include:

- Limited access to facilities where information is stored
- Policies and procedures for handling information
- Requirements for third parties to contractually comply with privacy laws
- All medical files and records (including email, regular mail, telephone, and faxes sent) are kept on permanent file

Types of information that we gather and use:

In administering your health care, we gather and maintain information that may include non-public personal information:

- About your financial transactions with us (billing transactions).
- From your medical history, treatment notes, all test results, and any letters, faxes, emails or telephone conversations to or from other health care practitioners
- From health care providers, insurance companies, workman's comp and your employer, and other third party administrators (e.g. requests for medical records, claim payment information).

In certain states, you may be able to access and correct personal information we have collected about you, (information that can identify you – e.g. your name, address, Social Security number, etc.).

We value our relationship, and respect your right to privacy.

By signing below I agree that I have read and acknowledge the above HIPAA regulations:

Signature: _____

Date: _____

Access Acupuncture Cancellation Policy

A missed appointment is a loss for everyone.

Should you need to cancel or reschedule an appointment, **24 HOURS NOTICE** is required. If you fail to notify us 24 hours in advance, **YOU WILL BE CHARGED \$40 FOR YOUR MISSED APPOINTMENT.** For a Monday cancellation, please call on Friday.

PATIENT SIGNATURE (or Patient Representative indicating relationship)

DATE

INFORMED CONSENT:

Acupuncture Provider

I hereby request and consent to acupuncture treatment and/or herbal supplement recommendations for me (or my legal charge) provided by the ASH Plans Contracted Provider of Acupuncture Services named above and/or other ASH Plans Contracted Provider of Acupuncture Services who may treat me. I understand that the ASH Plans Contracted Provider of Acupuncture Services will explain all known risks and complications, and I wish to rely on the ASH Plans Contracted Provider of Acupuncture Services to exercise judgment during the course of the procedure, which the ASH Plans Contracted Provider of Acupuncture Services determines is in my best interests. I may request another person of my choice to be present in the treatment room during treatment.

The ASH Plans Contracted Provider of Acupuncture Services has discussed with me the procedures listed below that may be used in my treatment. I have read the information below and understand the possible risk involved. I agree to the ASH Plans Acupuncture Provider's use of this treatment (if indicated).

- **Acupuncture** is a safe and effective method of treatment. However, it can occasionally cause slight bleeding that usually resolves with pressing dry cotton on the spot where the skin is bleeding. It is also normal for the patient to have a temporary warm, tight, sore or tingling sensation at the acupuncture site.
- **Acupressure/TuiNa** involves rubbing, kneading, pressing, and stroking, etc., which may result in muscle soreness at the massage site that can last several days. This technique may require disrobing. I understand all attempts will be made to assure my privacy
- **Indirect Moxibustion** requires burning an herbal material near the skin or on an acupuncture needle. Every precaution is taken to prevent skin contact, but the possibility of skin contact and mild burns exists. ASH Plans does not allow *direct* moxibustion where burning material contacts the skin.
- **Cupping** involves a localized suction produced by heating a small glass cup. There is a possibility of local bruising from the suction and slight burning or blistering due to the heat involved in the technique.
- **Gua Sha** involves scraping over a small area by using a smooth-edged instrument. There is a possibility that local bruising is likely to occur at the site where Gua Sha is performed.
- **Tapping, Plum Blossom, Bleeding, Pricking** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site is a likely occurrence. Only single-use needles are used in these procedures.
- **Electrical Stimulation/TENS** uses microcurrent electricity to stimulate acupuncture points. A mild tingling sensation of electricity will be felt.
- **Treatment Using Control Points Ren 1/Du 1.** In very rare cases, the Acupuncture Provider may recommend treatment using acupuncture points near the genital organs. If this is necessary, the Acupuncture Provider will notify me and will provide alternative treatments if I am uncomfortable with treatment using these points. I understand all attempts will be made to assure my privacy.

I have read, or have had read to me, the above consent, and have had the opportunity to ask questions and discuss this with my ASH Plans Contracted Provider of Acupuncture Services. I consent to the treatment that involves the above procedures for my present condition(s) and any future conditions. I have the right to refuse or discontinue any treatment at any time and understand that this refusal may affect the expected results.

Authorization for Release of Medical Information: I further understand that my ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager may need to contact my medical physician when the ASH Plans Contracted Provider of Acupuncture Services or an ASH Plans Acupuncture Clinical Services Manager have identified that my condition needs to be co-managed with my medical doctors. The conditions that may require co-management include but are not limited to; pregnancy related nausea, pain associated with Multiple Sclerosis, neuromusculoskeletal effects of stroke, pain/nausea related to cancer/tumor, chemotherapy related nausea, pain/nausea related to AIDS/ARC, pain or nausea related to surgery. This coordination of care intends to manage my health condition in my best interest and assure the optimal outcome of my acupuncture treatments. Therefore, I give my authorization to ASH Plans to contact my medical physician if/when necessary.

Treatment of Pediatric Patients <3 Years. I understand that treatment of young children has some risk and should be coordinated with the child's physician. If I am signing for my child under the age of eighteen (18), I give my authorization to ASH Plans to contact my child's medical doctor if/when necessary.

Patient Name (please print)

Patient ID Number

Primary Care Physician (or specialist) Name

Patient Signature

Primary Care Physician (or specialist) Telephone

Date