PATIENT INFORMATION FORM

PI ACUPUNCTURE CASH WC PT CHIROPRACTIC

Referring Doctor_____ Treating Doctor_____

First Name _____ M.I.___ Last Name _____

Birth Date ____/____/____ Age ____ SS#_____-_____-_____ Male____ Female_____

Marital Status_____ Spouse Name_____ DL#/STATE_____

Address _____ City _____ State_____

Zip _____ Home Phone_____ Wk Phone_____

Cell Phone _____Circle Best Contact Phone Number: Home Work Cell

Email _____ Employer _____

Referred By _____ Primary Doctor _____

Primary Insurance Co. Name & ID_____

Secondary/ Other Insurance Co. _____

I understand and agree that health and accident insurance policies are an agreement between and insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection. I also authorize the release of any medical or other information necessary to process this claim.

If the insurance company pays me directly I will bring the payment for the treatments along with an explanation of benefit endorsed by my signature to this office promptly.

Patient Signature _____ Date _____/_____/_____

I hereby request and consent to physical therapy and/or chiropractic and/or acupuncture treatment for me (or my legal charge) provided by the providers at Back To Wellness. I do not expect the provider to be able to anticipate and explain all known risks and complications, and I wish to rely on the provider to exercise judgment during the course of the procedure, which, the provider determines is in my best interest. I understand that there are some risks to treatment, including but not limited to, fractures, disc injuries, strokes, dislocations, and sprains. .I may request another person of my choice to be present in the treatment room during treatment.

Patient Signature _____ Date _____/_____/_____

Back To Wellness
Gerald E. Mason, L. Ac.

Informed Consent and Disclosure
12526 Riverside Dr., Valley Village, CA 91607 (818) 985-2559

Informed Consent: **Provider: Gerald E. Mason, L. Ac.**

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

The 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 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.

- **Traditional Chinese Herbal Supplements** recommended are traditionally considered safe. However, some patients may experience gastrointestinal upset or other reactions to the herbs. I will inform the provider immediately if I experience any side effects. I understand that I am fully responsible to inform the provider of any discomfort related to the use of herbal supplements. I understand that some herbs may be inappropriate during pregnancy. I accept full responsibility to inform the provider of a suspected or confirmed pregnancy, or if I am a nursing mother.

- **Acupressure/Tui Na** 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 moxa** 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. Direct moxibustion where burning material contacts the skin is not allowed in this clinic.

- **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, Prickling** all involve multiple needle pricks at a localized site. Slight bleeding and/or bruising at the treatment site are a likely occurrence. Only single used 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 Acupuncturist may recommend treatment using acupuncture points near the genital organs. If this is necessary, acupuncturist 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 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.

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 the Provider listed above to contact my child's medical doctor if/when necessary.

Patient Name (please print)	Patient ID number
Patient Signature	Primary Care Physician (or specialist) Name
Date	Primary Care Physician (or specialist) Telephone

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures or Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities or your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student's, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician.. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use and disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues and required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military, and National Security, Worker's Compensation, Inmates, Required uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care of fore notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance officer in person or by phone at our main phone number.

Signature below is only acknowledgment that you have received this notice of our Privacy Practices.

Print Name:_____ Signature:_____ Date: _____

New Patient Intake Form

Today's Date____/____/____

Have you had Acupuncture Before? ☐ Yes ☐ No Herbal Medicine? ☐ Yes ☐ No

Reason for Visit Today_____

How long have you had this condition?_____ Is it getting worse? ☐ Yes ☐ No

Does it bother your ☐ Sleep ☐ Work ☐ Other (what?) _____

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 If yes for what?_____

Who is your physician? _____ Physician's phone_____

Other concurrent therapies_____

Pharmaceuticals taken past 2 months_____

Other Supplements taken past 2 months_____

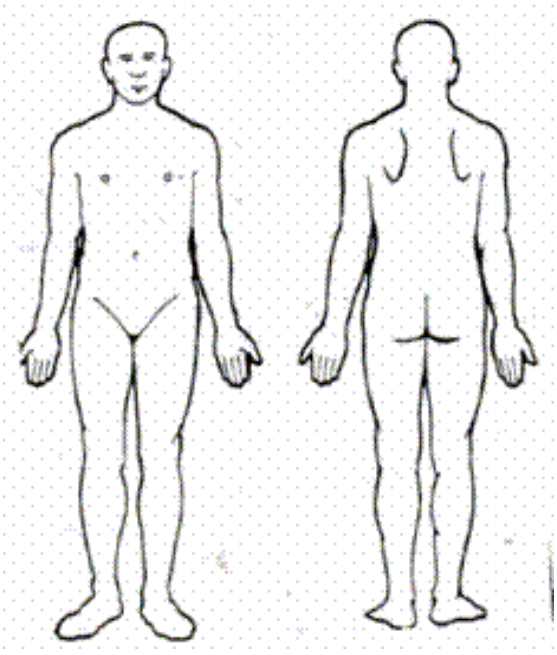
Family Medical History

☐Allergies ☐ Cancer

_____ _____

_____ _____

☐Diabetes ☐Seizures
☐Heart disease ☐ Stroke
☐ High blood pressure



Your Past Medical History

(Check any of the following conditions you currently have, or have had in the past. Please also check if you feel any of the following are a significant part of your medical history)

☐ AIDS/HIV	☐ Diabetes	☐ Multiple Sclerosis
☐ Tuberculosis	☐ Alcoholism	☐ Emphysema
☐ Measles	☐ Mumps	☐ Typhoid Fever
☐ Allergies	☐ Epilepsy	☐ Pacemaker
☐ Seizures	☐ Ulcers	☐ Appendicitis
☐ Goiter	☐ Pleurisy	☐Stroke
☐ Arteriosclerosis	☐ Heart disease	
☐ High blood pressure	☐ Thyroid disorder	☐ Gout
☐ Chicken Pox	☐ Whooping cough	☐ Polio
☐ Scarlet Fever	☐ Pneumonia	☐ Asthma
☐ Cancer	☐ Rheumatic fever	
☐ Herpes	☐ std	☐ Hepatitis
☐ Other (please specify)	☐ Surgery	☐ Major Trauma

_____ _____ _____
_____ _____ _____
_____ _____ _____

Your Lifestyle

☐ Alcohol ☐ Marijuana Stress Regular exercise
☐ Tobacco ☐ Drugs Occupational Hazards Type_____ Frequency_____
Type_____ Frequency_____

General Symptoms

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands & feet	☐ Night Sweats	☐ Peculiar tastes (describe)
☐ Strongly like cold drinks	☐ dream disturbed sleep	☐ Poor circulation	☐ Sweat easily	_____
☐ Strongly like hot drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps	_____
☐ Recent weight loss/gain	☐ Lack of strength	☐ Fever	☐ Vertigo or dizziness	_____

Head, Eyes, Ears, Nose, Throat

☐ Glasses
☐ Eye strain
☐ Eye Pain
☐ Red Eyes
☐ Itchy Eyes
☐ Spots in eyes
☐ Poor vision
☐ Blurred vision

☐ Night blindness
☐ Glaucoma
☐ Cataracts
☐ Teeth Problems
☐ Grinding teeth
☐ TMJ
☐ Facial Pain
☐ Gum Problems

☐ Sores on lips or tongue
☐ Dry Mouth
☐ Excessive saliva
☐ Sinus problems
☐ Excessive phlegm
Color of phlegm _____

☐ Recurrent sore throat
☐ Swollen glands
☐ Lumps in throat
☐ Enlarged thyroid
☐ Nose bleeds
☐ Ringing in ears
☐ Poor hearing
☐ Earaches

☐ Headaches
☐ Migraines
☐ Concussions
Other head or neck problems
_____
_____
_____
_____

Respiratory

☐ Difficulty breathing when lying down
☐ Shortness of breath

☐ Tight chest
☐ Asthma/wheezing

☐ Cough
Wet or dry?_____
Thick or thin?_____

☐ Coughing blood
☐ Pneumonia

Cardiovascular

☐ High blood pressure
☐ Blood clots

☐ Low blood pressure
☐ Fainting

☐ Chest pain
☐ Difficulty breathing

☐ Tachycardia
☐ Heart palpitations

☐ Phlebitis
☐ Irregular heartbeat

Gastrointestinal

☐ Nausea
☐ Vomiting
☐ Acid regurgitation
☐ Gas
☐ Hiccup
☐ Bloating

☐ Diarrhea
☐ Constipation
☐ Laxative use
☐ Black stools
☐ Bloody stools
☐ Mucous in Stool

☐ Intestinal pain or cramping
☐ Itchy anus
☐ Burning anus
☐ Rectal pain
☐ Hemorrhoid
☐ Anal Fissures

Bowel movements

Frequency _____
Color _____

☐ Bad Breath

Musculoskeletal

☐ Neck/shoulder pain
☐ Muscle pain

☐ Upper back pain
☐ Low back pain

☐ Joint pain
☐ Rib pain

☐ Limited range of motion
☐ Limited use

☐ Other (describe)
_____

Skin and Hair

☐ Rashes
☐ Hives
☐ Ulcerations

☐ Eczema
☐ Psoriasis
☐ Acne

☐ Dandruff
☐ Itching
☐ Hair loss

☐ Change in hair/skin texture
☐ Fungal infections

Other hair/skin problems
_____
_____

Neuropsychological

☐ Seizures
☐ Numbness
☐ Tics

☐ Poor memory
☐ Depression
☐ Anxiety

☐ Irritability
☐ Easily Stressed

☐ Considered/attempted suicide
☐ Seeing a therapist

Other (specify)
_____

Genito-Urinary

☐ Pain on urination
☐ Frequent urination
☐ Urgent urination

☐ Blood in Urine
☐ Unable to hold urine
☐ Incomplete urination

☐ Venereal disease
☐ Bedwetting
☐ Wake to urinate

☐ Increased Libido
☐ Decreased Libido
☐ Kidney stone

☐ Impotence
☐ Premature ejaculation
☐ Nocturnal emission

Gynegology

Age Menses began _____
Length of cycle (day 1 to 1)
☐ Painful periods

Duration of flow _____
☐ Irregular periods
☐ Vaginal odor

☐ Vaginal discharge (color)_____
☐ Vaginal sores
☐ Premature births____.

☐ Breast lumps
pregnancies_____
☐ Live births_____
☐PMS ☐ Clots

☐ Date of last PAP _____
Date last period began
Age at Menopause_____

Other_____

Stop Here

Pulse:_____ Tongue_____

Other:_____

Dx: _____

Points_____

_____

Tx Plan: _____/ Week ☐Based on medical necessity ☐As prescribed by PTP ☐As long as symptoms ☐Maintenence

Modalities: ☐Acupuncture ☐E-Stim ☐I/R ☐Mech. Tract. ☐Man Therapy ☐Cupping ☐Ther/exer

Short term goals: ↓Mms Spasm ↓ Inflammation ↑ROM ↓Pain

Long term goals: ↑Function ↑Strength ↑Balance ↑Stability

Herbs/Formulas:_____

Refer to ☐ Chiro ☐Ortho ☐ Neuro ☐ Internist ☐ Opth ☐ Other_____