FLYING TURTLE HEALING ARTS

Patient information and Health History

Patient information **Today's date:**

First name: Last name: Date of birth:

Street: City, State: Zip code:

Email address: Phone number: Age:

Occupation: How did you hear about Flying Turtle Healing Arts?

In the unlikely case of an emergency:

Who is your emergency contact person? Relationship:

Emergency Contact's phone number:

Primary Care Physician: Phone number:

Main complaint(s) / reason(s) for seeking treatment today

Medical History – check all that apply:

❑ Diabetes	❑ Cancer	❑ Stroke	❑ High blood pressure	❑ IBS
❑ Heart disease	❑ Seizures	❑ HIV	❑ Kidney disease	❑ Asthma
❑ Pacemaker	❑ Autoimmune	❑ Hepatitis	❑ Thyroid disease	❑ Depression

List any hospitalizations/surgeries, significant trauma, major accidents/injuries (include approximate dates):

Current medications and supplements (include prescription, OTC, vitamins, herbs):

Medication	Dosage	Date began	Reason for taking

Allergies (chemical, environmental, food, drugs, etc.)

Lifestyle

Are you on a particular type of diet? **Yes / No** If yes, please specify:

How is your appetite? ❑ Low ❑ Good ❑ Too good Do you have regular bowel movements? **Yes / No**

How much water do you drink in a day? _____ glasses/ounces

Do you consume any of the following? (check all that apply) Indicate how much:

❑	Coffee/tea	_____ per day/week	❑	Dairy	_____ per day/week
❑	Soda	_____ per day/week	❑	Meat	_____ per day/week
❑	Alcohol	_____ per day/week	❑	Fish	_____ per day/week

Do you smoke? **Yes / No** If yes, what do you smoke and how much:

Do you exercise regularly? **Yes / No** Please describe:

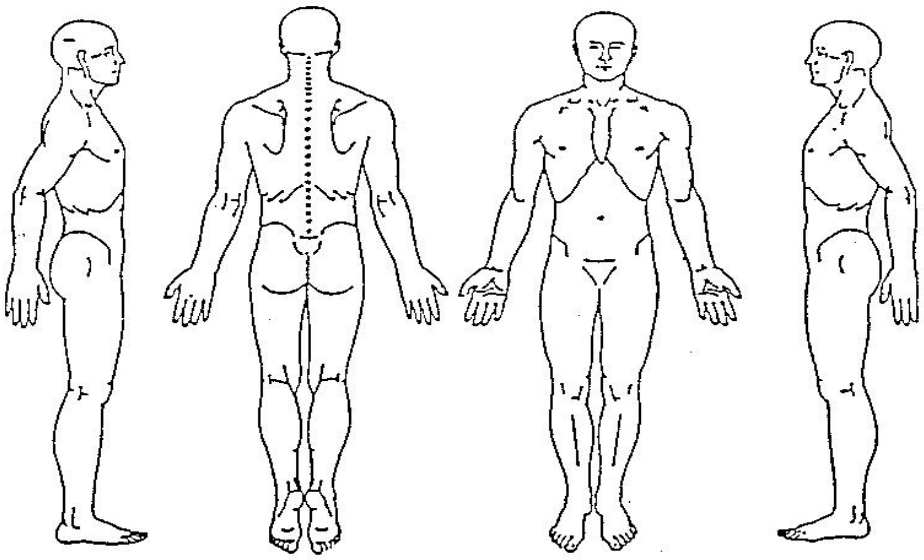
How many hours of sleep do you get on average? _____

Do you have trouble falling asleep? **Yes / No** Do you feel rested when you wake up? **Yes / No**

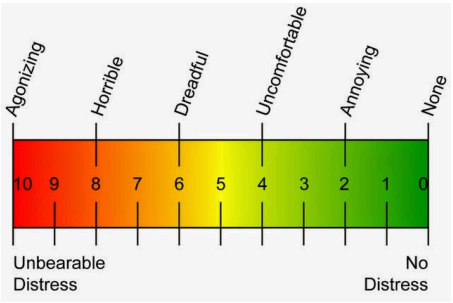
Do you have trouble staying asleep? **Yes / No** What keeps you up? _____

Are there areas of your life that you find particularly stressful? _____

Mark any areas of pain or discomfort below:



How bad is it today?



Menstrual/GYN History (if applicable)

Age of first menses: ____ years old Average days between periods (length of cycle): ____ to ____ days

Do you have a regular period? **Yes / No** Average length of period: ____ days flow

If not, are you in menopause? **Yes / No** Heaviest day/s (circle): Day/s 1 2 3 4 5 6 7

Are you pregnant? **Yes / No** Is it possible that you are pregnant? **Yes / No**

Do you practice birth control? **Yes / No** If yes, what type? _____ Since when? _____

When was your last period? _____ Do you experience PMS? **Yes / No**

ACUPUNCTURE INFORMED CONSENT TO TREAT

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, moxibustion, cupping, electrical stimulation, Tui-Na (Chinese massage), Chinese herbal medicine, and nutritional counseling. 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 have been informed that acupuncture is a generally safe method 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. 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.

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. 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.

ACUPUNCTURIST NAME: Fannie Koa, Lic. Ac., MAOM

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

FLYING TURTLE HEALING ARTS
ACUPUNCTURE AND CHINESE HERBAL MEDICINE
259 Elm St. Suite 300B Somerville MA 02144

Financial Agreement - Health Insurance

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care we can provide for your condition. In order to familiarize you with the financial policy of this office we would like to explain how your medical bills will be handled.

Explanation of Insurance Coverage

Many insurance policies do cover acupuncture care, but this office makes no representation that yours does. Insurance policies vary greatly in terms of deductible, copayment/co-insurance, number of sessions covered, referral requirements, and health conditions that qualify for acupuncture benefits.

As a courtesy we will bill your insurance carrier directly. However, it must be understood that the contract is between you and your insurance carrier and you are responsible for any amount that they do not pay.

We will do our best to verify your insurance coverage before billing, and will submit claims in a timely manner. Please note that verification of benefits does not guarantee payment by the insurance company. If your insurance company fails to pay as expected, we will make an effort to resolve the issue before passing the bill along to you.

Initial _____

Assignment of Benefits

By signing this form you are authorizing payment of medical benefits will be made directly to this office. If your insurance carrier sends payment to you for services incurred in this office, you agree to send or bring those payments to this office upon receipt.

If you choose to pay for your treatment out of pocket and submit the receipts to your insurance company for reimbursement, payment will be sent directly to you.

Initial _____

Release of information

By signing this for you are also authorizing this office to provide your insurance carrier with any medical or other information necessary to process the insurance claims for your treatment.

Initial _____

Payment Arrangements

Your co-payment or co-insurance is due at the time of service.

If you have not met your plan's deductible for the year, payment in full is required at the time of service. As a courtesy we will submit the claim to your insurance company so that you will receive credit toward your deductible. If you pay for a session that is later also paid by your insurance company, we will refund the portion of your payment that was reimbursed by insurance, up to the amount you paid less any co-payment or co-insurance assigned to you by the insurer.

Please note that we typically bill insurance at higher rates than the self-pay rate, which represents a discount for payment at the time of service. If you pay a co-insurance that is calculated as a percentage, this may affect the amount of your out of pocket payment. The actual reimbursement rate, and your co-insurance amount, are determined by your insurance company.

If your insurance pays less than the self-pay rate, you may owe us the difference. Once we receive payment (or notification of non-payment) from your insurance, we will bill for any remaining unpaid amount unless our contract with your provider prevents us from doing so. It typically takes between four and twelve weeks for your insurance company to process a claim.

Initial _____

Cancellation Policy

Your appointment time is reserved specifically for you. We require at least 24 hours notice to cancel or reschedule an appointment.

Appointments that are canceled or changed with less than 24 hours notice are subject to a cancellation fee equal to the self-pay rate for the session. Please note that insurance will not pay for a missed session, and you will need to pay out of pocket for any cancellation fees.

I have read and agree to the above.

Name _____

Signature _____

Date _____