Northwest Acupuncture

10224 SW Park Way, Suite A Portland, OR 97225
ph: 503.297.1174 fax: 503.297.2623

PATIENT INFORMATION

_____ _____ _____ _____ _____
Last Name First Name MI Gender M/F How did you hear about us?

_____ _____ _____ _____
Street Address City State & Zip Code Marital Status?

(____)_____(____)_____(____)_____/_____/_____
Home Phone # Cell Phone # Work Phone # Email Address DOB

_____(____)_____
Employer's Name Occupation Emergency Contact Emergency Contact Ph #

PRIVATE HEALTH INSURANCE

_____/_____/_____
Name of Insured & Employer Insured DOB Relationship to Insured

_____(_____)_____
Insured Address & Phone # (if different from patient) Insurance Co Name

AUTO INSURANCE (Complete if you were in an auto accident. WE MUST bill Auto Insurance of the car you were in)

_____ _____ _____
Name of Insured Insurance Co. Name Insurance Claims Address

_____/_____/_____
Claim # Policy # Date of Accident

WORKMEN'S COMPENSATION INSURANCE (Complete if you had a work-related accident. This information can be obtained from your employer.)

_____ _____
What kind of accident? Driver's License #

_____(_____)_____
Employer's Name Employer's Address Employer's Phone #

_____(_____)_____
Employer's Insur. Carrier Name & Address Claims Phone #

_____ _____ _____
Claim # Date of Accident Social Security Number

RECORDS RELEASE (Please read and sign)

I hereby authorize the release of any medical or other information necessary to process my claim for medical benefits. I authorize my Insurance Company to issue payment directly to this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

_____ _____
Patient or Parent/Legal Guardian for patient under 18 years of age Date

_____ _____
Witness's Signature Date

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FINANCIAL RESPONSIBILITY AGREEMENT

Policy:

1. All patients not covered by insurance must pay at time of service.

2. All co-pays, deductibles, and balances will be collected at the time of service.

3. In those cases where your insurance company denies payment, you are responsible for costs incurred. Payment is expected before the end of the billing month.

4. Any balances due to Total Health Wellness Center Providers after your Insurance carrier has notified the Clinic of payment or non-payment will be billed to you.
After thirty (30) days of the first bill, a finance charge of $2.50 per month will begin to apply to your account. Any bill over ninety (90) days past due will be subject to collection procedures.

If you need to make payment arrangements, you can do so by contacting our Billing office. Once you agree to a payment plan, you will sign on your agreement. All payment agreements must be followed through within the allotted timeline.

We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic.

I, _____ (patient's name or name of parent/legal guardian or responsible/legal party) as a patient of Total Health Wellness Center, acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

_____

Signature of Patient or Parent/Legal Guardian/Responsible Party

_____

Patient's Printed Name

Date _____

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In Yu, DAOM, LAc

Confidential Patient Health Record

Patient Name: **Date:**

Who referred you to us? File #: _____

Marital Status: **S M D W** Gender: M / F_____

Successful health care and preventative medicine are only possible when the Practitioner has a complete understanding of the Patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

When and where did you last receive health care? _____

For what reason? _____

Has your case been referred to an attorney? ☐ Yes ☐ No

Please identify the health concerns that have brought you to our clinic, in order of importance below:

	Condition	**Past Treatment**
1.	_____	_____
	How does this condition affect you? _____	
2.	_____	_____
	How does this condition affect you? _____	
3.	_____	_____
	How does this condition affect you? _____	

If applicable, please list any foods, drugs or medications you are hypersensitive or allergic to (include reaction)

_____

_____

_____

Please list all medications (prescribed or over-the-counter), vitamins and supplements you are currently taking

_____

_____

_____

Do you have any reason to believe you may be pregnant? ☐ Yes ☐ No (If so, how far along?:_____)

Do you have any infectious diseases? ☐ Yes ☐ No If yes, please identify: _____

Height: _____ **Weight: Currently:** _____ **Past Maximum:** _____ **When?:** _____

Blood Pressure: What is your most recent blood pressure reading? _____ /_____ **When taken?** _____

Childhood Illness (Please circle any that you have had):

Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

Immunizations (Please circle any that you have had):

Polio Tetanus Rubella/Mumps Pertussis Diphtheria Hib Hepatitis B

Others: _____

Hospitalizations and Surgeries:

Reason	When	Reason	When
_____		_____	

X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When
_____		_____	

Please circle any that you experience now and underline any that you have experienced in the past:

Emotional Mood Swings Nervousness Stressed Easily

Energy and Immunity Fatigue Chronic Infections Chronic Fatigue Syndrome

Head, Eye, Ear, Nose, and Throat
Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness
Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems
Nose Bleeds Frequent Sore Throats Teeth Grinding TMJ/Jaw Problems Hay Fever

Respiratory
Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough
Pleurisy Asthma Tuberculosis Shortness of Breath Other: _____

Cardiovascular
Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Stroke
Palpitations/Fluttering Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal
Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heart Burn Belching
Gall Bladder Disease Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Genito-Urinary Tract
Kidney Disease Painful Urination Frequent UTI Frequent Urination Heavy Flow
Kidney Stones Impaired Urination Blood in Urine Frequent Urination at Night

Female Reproductive/Breasts
Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Vaginal Discharge Clotting
Premenstrual Probs. Bleeding Between Cycles Menopausal Sympts. Diffic. Conceiving Painful Periods

Menstrual/Birthing History
1. Age of First Menses: _____ 2. # of Days of Menses: _____ 3. Length of Cycle: _____
4. Birth Control Type: _____ 5. # of Pregnancies: _____ 6. # of Miscarriages: _____
7. # of Abortions: _____ 8. # of Live Births: _____

Male Reproductive Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

Musculoskeletal
Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain
Low Back Pain Leg Pain Joint Pain (if so, where?) _____

Neurologic
Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine
Hypothryroid Hypoglycemia Hyperthyroid Diabetes Mellitus Night Sweats Feeling Hot or Cold

Other Anemia Cancer Rashes Eczema/Hives Cold Hands/Feet
Is there anything else we should know? _____
_____

Lifestyle: Do you typically eat at least 3 meals per day? ☐ Yes ☐ No If no, how many? _____
Exercise routine: _____
How many hrs per night do you sleep? _____ Do you wake rested? _____
Hours worked per week: _____Nicotine/Alcohol/Caffeine Use: _____
Have you experienced any major traumas? ☐ Yes ☐ No Explain: _____
_____
Interests/Hobbies: _____

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Authorization & Consent to Examine & Treat

To Whom It May Concern:

I hereby authorize the Providers of Total Health Wellness Center to administer all Medical examination procedures as deemed necessary. I have reported all health conditions that I am aware of and will inform my Practitioner of any changes in my health.

_____ _____

Patient signature Date

Our Cancellation Policy

Since your appointment time is important and reserved especially for you, we ask that you please call AS SOON AS POSSIBLE, preferably 24 hours in advance, to make any changes to it. This allows us to offer that time to another patient who needs care.

We reserve the right to charge a Missed Appointment Fee of $55.00 to those patients who miss their appointment without notifying us, or who repeatedly cancel with less than 24 hours notice.

We value your business and strive to ensure that we are always available to you, as well as the rest of our patients, when you need us.

Thank you.

I understand and agree to the above:

Patient Signature: _____ **Date:** _____

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Acknowledgement of receipt of Notice of Patient Privacy Practices

I have received the NOTICE OF PATIENT PRIVACY PRACTICES, which describes how The Providers and Representatives of **Total Health Wellness Center** may use and disclose my protected health care information to carry out treatment, payment of services, health care operations and other purposes that are allowed by law. This notice also describes my patient rights and the requirements of **Total Health Wellness Center** to protect my health information.

Total Health Wellness Center reserves the right to change the privacy practices that are described in the NOTICE OF PATIENT PRIVACY PRACTICES. All changes will be posted in the clinic. I understand that I may request a copy of this notice at any time and discuss its content with the Privacy Officer.

Signature of Patient or Personal Representative **Date**

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**