Acupuncture New Patient Questionnaire

Today's Date _____

Name _____ E-mail address _____

Phone: Cell_____ Home _____Social Security (VA ONLY)_____

Address_____City_____ State _____

Zip_____ Occupation_____ Employer _____

Emergency Contact: Name _____Phone _____

Primary Care Practitioner: _____ Sex M / F Birth date _____ Age _____

Marital Status _____ No. of Children _____

Is this your first time getting acupuncture? **Y** / **N** How did you hear about us? _____

Major Symptoms: Please list in order of importance what symptoms are of concern to you. (most concerning to least, along with the duration of the symptom)

1)_____

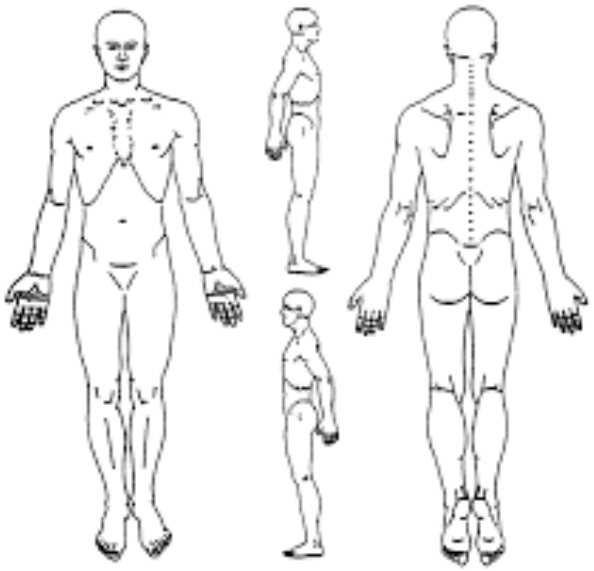
2)_____

3)_____

4)_____

Are you experiencing pain/discomfort in any area of your body? **Y / N**

Please rate your pain level. 1 2 3 4 5 6 7 8 9 10



List any medications or supplements you have taken in the last 2 months.

_____

_____

_____

_____

Use the picture below to indicate the location of the discomfort by using the symbol that best describes the feeling:

N N N Numbness

P P P Pins & Needles

D D D Dull/Aching

T T T Tightness

X X X Sharp/Stabbing

Please list any surgeries or major injuries with dates.

_____

_____

_____

Do you have a pacemaker or any metal devices in your body? Y / N

Do you have an exercise routine? Please describe.

_____

How many hours per night do you sleep on average?

_____

Do you wake rested? Y / N

Nicotine Use: _____

Alcohol Use (#drinks/week and type):

_____

Caffeine Use (#drinks/day and type): _____

_____

_____

Please check all that apply

Energy and Immunity

__ Fatigue

__ Allergies

(Specify)_____

__ Anemia

__ Chronic Fatigue Syndrome

__ Thyroid Problems

__ Tendency to Catch Colds

Head, Eye, Ear, Nose, and Throat

__ Eye Dryness

__ Blurry Vision

__ Poor Night Vision

__ Ear Ringing

__ Hearing Difficulties

__ Headaches / Migraines

__ Teeth Grinding / TMJ

__ Sore Throat

__ Chronic Sinus Congestion

__ Dry Mouth

__ Bad Breath

__ Mouth Sores / Bleeding Gums

__ Increase in Thirst

Emotions / Sleep

__ Mood Swings

__ Anxious / Worried

__ Depressed

__ Irritable

__ Difficulty Making Decisions

__ Stressed

__ Insomnia

__ Nightmares

__ Difficulty Falling or Staying Asleep

Respiratory/Cardiovascular

__ Shortness of Breath

__ Asthma

__ Chest Pain

__ Palpitations / Fluttering

__ Poor Circulation (Cold hands/feet)

__ Chronic Cough

__ Night Sweats

__ Unusual Sweating

__ Hot/Cold Intolerance

Gastrointestinal

__ Ulcers

__ Changes in Appetite

__ Nausea / Vomiting

__ Bloating / Pain

__ Gas

__ Heartburn / Acid Reflux

__ Belching

__ Hemorrhoids

__ Diarrhea

__ Constipation

__ Sudden Weight Change

Kidney/Urinary

__ Painful Urination

__ Frequent Urinary Tract Infections

__ Frequent / Urgent Urination

__ Edema / Swelling

Musculoskeletal

__ Neck / Shoulder Pain

__ Muscle Spasms / Cramps / Weakness

__ Arm Pain

__ Finger Pain / Tingling / Numbness

__ Upper Back Pain

__ Mid Back Pain

__ Low Back Pain

__ Leg / Knee Pain

__ Foot / Ankle Pain

__ Hip / Pelvic Pain

__ Arthritis

Neurological

__ Vertigo / Dizziness

__ Numbness / Tingling

__ Difficulty Concentrating / Poor Memory

Skin

__Rashes / Eczema / Hives / Psoriasis

__ Dry Hair or Hair Loss

__ Changes in Skin Color

__ Easy Bruising

__ Acne

__ Dry / Itchy Skin

Female Health

__ Irregular Cycle

__ Heavy Flow

__ Light Flow

__ Clots in Menstrual Blood

__ Menstrual Related Moodiness

__ Menstrual Related Breast Tenderness

__ Menstrual Related Bloating

__ Bleeding Between Cycles

__ Painful Periods (Is pain before, during and/or after period?

__ Hot flashes

__ Vaginal Dryness

__ Breast Lumps / Cysts

__ Uterine Fibroids

__ Endometriosis

__ Ovarian Cysts

__ Unusual Vaginal Discharge Odor

__ Frequent Yeast Infections

__ Decreased Libido

Male Health

__ Prostate Enlargement

__ Impotence

__ Premature Ejaculation

__ Decreased Libido

__ Groin Pain

Medical History

Do you or have you had any of the following conditions? If yes, please indicate date of diagnosis.

Cancer type:_____

__Diabetes

__Heart Disease

__Hepatitis

__High Blood Pressure

__High Cholesterol

__HIV

__Mental Illness Seizures

__Stroke

__Thyroid Disease

Other

_____

Point of Renewal
ACUPUNCTURE

Point of Renewal Acupuncture, LLC
Maria L Johnson Narveson, Lac.
610 A-2 West Avenue Rice Lake, Wi 54728
(715)296-7467

Consent to Privacy Policy, Payment and Health Care Operation

I consent to the use or disclosure of my identifiable health information by Point of Prosperity, LLC dba Point of Renewal Acupuncture for the purposes of diagnosis or providing treatment to, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me at Point of Renewal Acupuncture may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my identifiable health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Point of Renewal Acupuncture is not required to agree to the restrictions that I may request. However, if Point of Renewal Acupuncture agrees to a restriction that I request, the restriction is binding upon Point of Renewal Acupuncture.

I have the right to revoke this consent, in writing, at any time except to the extent that Point of Renewal Acupuncture has taken action in reliance on this consent.

My *identifiable health information* means health information, including my demographic information, collected from me and created or received by my practitioner, another health care provider, a health plan, my employer or a health care clearinghouse. This identifiable health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Point of Renewal Acupuncture Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my identifiable health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Point of Renewal Acupuncture. The Notice of Privacy Practices is also provided at the front desk and on the organization's web site at www.pointofrenewalacupuncture.com. This Notice of Privacy Practices also describes the rights and the duties of my practitioners and staff with respect to my identifiable health information. Point of Renewal Acupuncture reserves the right to change information contained in the Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the website or requesting the most current notice during any office visit.

_____ _____
Signature of Patient or Authorized Representative Date

_____
Printed Name and Relationship if under 18 years of age

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ACUPUNCTURE

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Maria L Johnson Narveson, Lac.
610 A-2 West Avenue Rice Lake, Wi 54728
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Consent to Treatment Form

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at the Chinese Medical Clinic. I understand that acupuncturists practicing in the state of Wisconsin are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to acupuncture treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effect may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. *Should I experience any problems, which I associate with these substances, I should suspend taking them and call Point of Renewal Acupuncture, LLC as soon as possible.*

Acupressure/Tui-Na Massage/Cupping: I understand that I may also be given acupressure/tui-na massage/cupping as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____
Date: _____
Printed Name: _____
Practitioner Signature:_____ **Date:**_____

Point of Renewal
ACUPUNCTURE & CBD OIL

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FINANCIAL AGREEMENT

Cash Payment Patients
- Payment is due at the time of service.

Health Insurance Patients
- Co-pay or co-insurance is due at the time of service. Any optional therapies chosen by you and not covered by insurance are also due at time of service.

Auto Insurance Claims
- Patients with injuries related to an auto accident must inform Point of Renewal Acupuncture at the time of their first appointment.

Other
- We have a 24-hour cancellation policy.
- Balances due that are not paid within 90 days will be sent to collections.
- A 1% service charge will be applied to any unpaid balanced past 30 days.

INSURANCE PATIENTS

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

- Our office does not guarantee that your insurance will pay. Some insurance companies do not cover acupuncture. We will assist you, if necessary, in making every attempt to receive verification of your policy. If for any reason your claim is denied, you are responsible for the full amount of your bill.

- Our office will not enter into a dispute with your insurance company over any unpaid claim.

- If your insurance requires a referral from your primary care physician for treatment, you will be responsible for payment of all services until our office has received a hard copy of the referral. If at a later date your insurance reimburses for services that you paid for at the time of the visit, that amount will be refunded to you.

- Failure to provide us with adequate information regarding your insurance may result in a denial from your insurance carrier and you will be responsible for any unpaid balance. Please make sure that we have all the necessary information to process your claim.

- A copy of our fee schedule is available upon request.

ASSIGNMENT AND RELEASE

I hereby authorize my benefits to be paid directly to Point of Renewal Acupuncture. I am financially responsible for any balance due. I also authorize the practitioner(s) listed to release any information required for this claim.
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.

BY SIGNING BELOW, YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF THE FINANCIAL POLICIES DESCRIBED ABOVE.

I HAVE READ AND UNDERSTAND THESE POLICIES AND MY RESPONSIBILITY CONCERNING THE PAYMENT OF THESE SERVICES.

Print Name _____ Relationship to Patient _____

Signed _____ Date _____

COVID-19 INFORMED CONSENT TO TREAT

I understand that the novel Coronavirus (COVID-19) has been declared a global pandemic by the World Health Organization (WHO). I further understand that COVID-19 is extremely contagious and may be contracted from various sources. I understand COVID-19 has a long incubation period during which carriers of the virus may not show symptoms and still be contagious.

I understand that I am the decision maker for my health care. Part of this office's role is to provide me with information to assist me in making informed choices. This process is often referred to as "informed consent" and involves my understanding and agreement regarding recommended care, and the benefits and risks associated with the provision of health care during a pandemic. Given the current limitations of COVID-19 virus testing, I understand determining who is infected with COVID-19 is exceptionally difficult.

To proceed with receiving care, I confirm and understand the following (Initial in all seven places provided) **Initial Below**

- I understand my treatment may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____
- I understand that I am opting for an elective treatment that may not be urgent or medically necessary, and that I have the option to defer my treatment to a later date. However, while I understand the potential risks associated with receiving treatment during the COVID-19 pandemic, I agree to proceed with my desired treatment at this time. _____
- I understand due to the frequency of appointments with patients, the attributes of the virus, and the characteristics of procedures, I may have an elevated risk of contracting COVID-19 simply by being in a health care office. _____
- I confirm I am not experiencing any of the following symptoms of COVID-19 that are listed below: _____

  *Fever *Dry Cough *Sore Throat
  *Shortness of Breath *Runny Nose *Loss of Taste or Smell

- I understand travel increases my risk of contracting and transmitting the COVID-19 virus. I verify that I have NOT in the past 14 days I have not traveled: 1) Outside of the United States to countries that have been affected by COVID-19; or 2) Domestically within the United States by commercial airline, bus, or train. _____
- I am informed that you and your staff have implemented preventative measures intended to reduce the spread of COVID-19. However, given the nature of the virus, I understand there may be an inherent risk of becoming infected with COVID-19 by proceeding with this treatment. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment and give my express permission to you and the staff at your offices to proceed with providing care. _____
- I have been offered a copy of this consent form. _____

I KNOWINGLY AND WILLINGLY CONSENT TO THE TREATMENT WITH THE FULL UNDERSTANDING AND DISCLOSURE OF THE RISKS ASSOCIATED WITH RECEIVING CARE DURING THE COVID-19 PANDEMIC. I CONFIRM ALL OF MY QUESTIONS WERE ANSWERED TO MY SATISFACTION.

I HAVE READ, OR HAVE HAD READ TO ME, THE ABOVE COVID-19 RISK INFORMED CONSENT TO TREAT. I APPRECIATE THAT IT IS NOT POSSIBLE TO CONSIDER EVERY POSSIBLE COMPLICATION TO CARE. I HAVE ALSO HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENT, AND BY SIGNING BELOW, I AGREE WITH THE CURRENT OR FUTURE RECOMMENDATION TO RECEIVE CARE AS IS DEEMED APPROPRIATE FOR MY CIRCUMSTANCE. I INTEND THIS CONSENT TO COVER THE ENTIRE COURSE OF CARE FROM ALL PROVIDERS IN THIS OFFICE FOR MY PRESENT CONDITION AND FOR ANY FUTURE CONDITION(S) FOR WHICH I SEEK CARE FROM THIS OFFICE.

Patient	Parent / Guardian	Witness
Signature: _____	Signature: _____	Signature: _____
Name: _____	Name: _____	Name: _____
Date: _____	Date: _____	Date: _____