ZYTO Questionnaire

Today's Date_____

Name _____ E-mail address _____

Phone: Cell_____ Home _____

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)_____

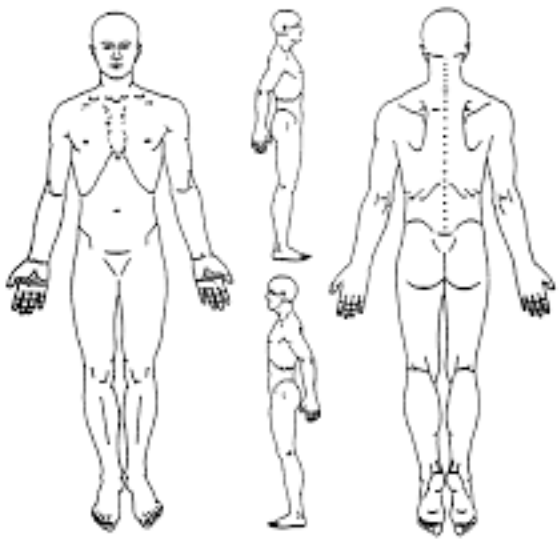
2)_____

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



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.

_____

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

_____

_____

_____

_____

_____

_____

_____

_____

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

Point of Renewal
ACUPUNCTURE

Point of Renewal Acupuncture, LLC
Maria L Johnson Narveson, L. Ac.
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

Point of Renewal
ACUPUNCTURE & CBD OIL

Maria L Johnson Narveson, NAc.
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Rice Lake, Wi 54868
715.296.7467 info@pointofrenewal.com

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