

Acupuncture Works LLC

24850 SE Stark St Ste 200 Gresham OR 97030

Phone: 503.665.9355

Michelle G. Blackwood LAc.

Licensed Acupuncturist

Confidential Patient Information

Important: Complete these forms as thoroughly as possible. Some questions may seem unrelated to your condition but they may affect your diagnosis and treatment. All information is confidential.

Name:
Last _____ First _____ M _____ Preferred First _____

Gender M _____ F _____ Date of birth _____ Age _____ Marital status _____

Address _____ City _____ State _____ Zip _____

Phone/Home _____ Phone/Work _____ Phone/Cellular _____

Emergency Contact _____ Relationship _____ Phone # _____

Whom may we thank for referring you? Friend _____ Doctor _____ Google _____ Yahoo _____ Insurance _____ Other _____

Email (only for appointments and communication): _____

Office Policies

* Treatment session begin & end at scheduled times. Sessions delayed due to patient arriving late end at appointed time. _____

* Patients provide a health history and update their health history and contact information when necessary. _____

* If cancellation is necessary 24 hour notice is required. If you fail to give notice or do not arrive for your appointment you will be charged \$35.00. Emergency cancellations are determined at the practitioner's discretion. _____

* In the event that a personal check is returned "with insufficient funds" a \$30.00 service charge will be applied. _____

Insurance Company _____ ID# _____ Group# _____

If insurance is to be billed by our office please read, sign and date the following

Assignment of Benefits/Release of Records/Payment Agreement

I hereby direct and instruct my insurance company to make payment directly to Acupuncture Works LLC for medical claims submitted on my behalf for medically necessary treatment. I hereby authorize Acupuncture Works LLC to furnish any and all records, reports or information as may be requested in reference to my case and treatment, to any and all treating physicians, attorneys or insurance companies. I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company that which is due to you for my medically necessary care and treatment. I agree and acknowledge that I am ultimately responsible to you for payment of any balance due, including unpaid deductible and/or unpaid percentage amounts due to you according to my policy coverage. In the event you are unable to collect from my insurance carrier or attorney in the case where you are holding an attorney lien on my behalf, I am responsible for the balance due.

Patient Signature _____ Date _____

Confidential Patient Information – Pg2

Patient Name _____

Date _____

Major complaint(s), in order of importance to you:

_____	_____	Mild	_____	Moderate	_____	Severe
_____	_____	Mild	_____	Moderate	_____	Severe
_____	_____	Mild	_____	Moderate	_____	Severe

Major SURGERY/HOSPITALIZATIONS: _____

Major INJURIES/ACCIDENTS: _____

Height _____ Weight _____ Have you lost or gained weight in the past year? Gained? _____ Lost? _____

Do you participate in a regular EXERCISE routine? What activities and how often per week? _____

How many hours of SLEEP per evening? _____ Are you satisfied with your sleep? _____ If not, why? _____

HABITS (Note typical quantity consumed) _____ Tobacco _____ Recreational Drugs _____
_____ Coffee _____ Tea _____ Herbal Tea _____ Soda _____ Alcohol _____ Sugar _____

ALLERGIES: Medications, Seasonal, Environmental, Food (Please List) _____

OCCUPATIONAL CONCERNS: _____ Frequent Computer/Typing/Mouse use _____ Toxic Substances
_____ High Stress _____ Unusual Hours (swing or graveyard shifts)
_____ Other _____

MEDICATIONS (Please list prescriptions and supplements and their purpose and doses) _____

Confidential Patient Information – Pg 3

Patient
Name _____

Date _____

For each symptom you CURRENTLY have rate severity from 1-5 (5 at its worst). Leave blank if not applicable.

- | | | |
|-----------------------------------|-------------------------------------|---|
| Irritability _____ | Breathlessness _____ | Itchy skin _____ |
| Depression _____ | Vivid dreams _____ | Grief, sadness _____ |
| Headaches/migraines _____ | Dreams are bothersome _____ | Shortness of breath _____ |
| Visual problems _____ | Lack of joy in life _____ | Allergies _____ |
| Red eyes _____ | Laughing for no reason _____ | Craving/avoiding spicy food _____ |
| Dry itchy eyes _____ | Craving/avoiding bitter foods _____ | Heaviness anywhere in body _____ |
| Spots in front of eyes _____ | Urinary problems _____ | Fatigue _____ |
| Blurred vision _____ | Frequent urination _____ | Hard to get up in the morning _____ |
| Feeling of lump in throat _____ | Incontinence _____ | Edema (swelling) _____ |
| Clenching of teeth at night _____ | Weakness/pain in lower back _____ | Muscles feel tired often _____ |
| Muscle cramping _____ | Aching bones _____ | Easy bruising and bleeding _____ |
| Muscle twitching _____ | Feel cold easily _____ | Bad breath _____ |
| Joints feel tight/stiff _____ | Low sexual desire _____ | Low appetite _____ |
| Cold hands/feet _____ | Poor memory _____ | Snacking _____ |
| Gas/belching _____ | Loss of hair _____ | Low blood sugar _____ |
| Soft/brittle nails _____ | Hearing problems _____ | Difficulty digesting oily foods _____ |
| Bloating _____ | Excess sexual desire _____ | Hemorrhoids _____ |
| Craving/avoiding sour foods _____ | ringing in ears _____ | Nausea _____ |
| Abdominal pain _____ | Craving/avoiding salty food _____ | Vomiting _____ |
| Indigestion/heartburn _____ | Dry cough _____ | Diarrhea _____ |
| Heart palpitations _____ | Cough with sputum _____ | Constipation _____ |
| Chest pain _____ | Nasal discharge _____ | Over thinking _____ |
| Dizziness _____ | Poor sense of smell _____ | Tendency to become obsessive _____ |
| Insomnia _____ | Nose bleeds _____ | Craving/avoiding sweets _____ |
| Easily startled _____ | Itchy, red or painful throat _____ | Low resistance to colds or flu _____ |
| Restlessness/agitation _____ | Dry mouth _____ | Low physical stamina _____ |
| Anxiety _____ | Skin rashes _____ | Mild fever comes and goes _____ |

WOMEN'S HEALTH: Last menstrual cycle _____ Last pap smear _____ Form of birth control _____

Do you experience: _____ Painful periods _____ Painful breasts _____ Vaginal dryness _____ Vaginal discharge
 _____ Irregular periods _____ Heavy bleeding _____ Clotting _____ Water retention _____ Back ache
 _____ Hot flashes _____ Night sweats _____ Miscarriage _____ # of vaginal deliveries

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HIPAA PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amount the multiple healthcare providers who may be directly or indirectly involved in that treatment.
- Obtain payment from third-party payers
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Michelle Blackwood has the right to change the Notice of Privacy Practices from time to time and that I may contact her at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing to restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Patient Signature: _____

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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 Michelle Blackwood 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 Michelle Blackwood, including those working at the clinic or office listed above 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 be 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. 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. Burns and/or scarring are a potential risk of moxibustion and cupping. I understand that while this document describes the major risks of treatment, other side effect 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.

I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, and 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.

X _____

PATIENT SIGNATURE (Or Patient Representative)

DATE _____