Island Acupuncture
& Massage Therapy

Patient General Information

GENERAL PATIENT INFORMATION

Last Name ______________________ First Name ______________________

Home Phone ______________________ Cell Phone ______________________

Work Phone ______________________ Email ______________________

Address ____
(street) (city) (state) (zip)

Date of Birth ______________________ Occupation ______________________

Marital Status ______________________ Age ______________________

Name of Emergency Contact Person ______________________

Phone Number for Emergency Contact Person ______________________

Your Primary Care Physician ______________________

Are you or your spouse a veteran? ☐ Yes ☐ No

Do you or your spouse work for the Dare County school system? ☐ Yes ☐ No

Who can we thank for referring you? ______________________

PATIENT INSURANCE INFORMATION (see attached Insurance Information & Checklist)

Insured's ID Number ______________________ Insured's Policy Number ______________________

Insurance Plan Name or Program Name ______________________

Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child

If Relationship is other than "Self," what is Insured's name and DOB? ______________________

FOR OFFICE USE ONLY
ICD-9 CODE(S): ______________________ DATE OF FIRST TREATMENT: ______________________

Health Concerns

MAIN CONCERN: ____

How does this problem affect your daily activities? ______________________________

____

____

____

When did you first notice symptoms? ______________________________________

____

What kinds of treatment or therapies have you tried? ____________________________

____

____

Present Health Concerns

Please list most important health concerns in order of significance

Prior diagnosis of this problem? If so, what?

1. ______________________ ______________________
2. ______________________ ______________________
3. ______________________ ______________________
4. ______________________ ______________________
5. ______________________ ______________________

HOSPITALIZATIONS/SURGERIES/ACCIDENTS: ______________________

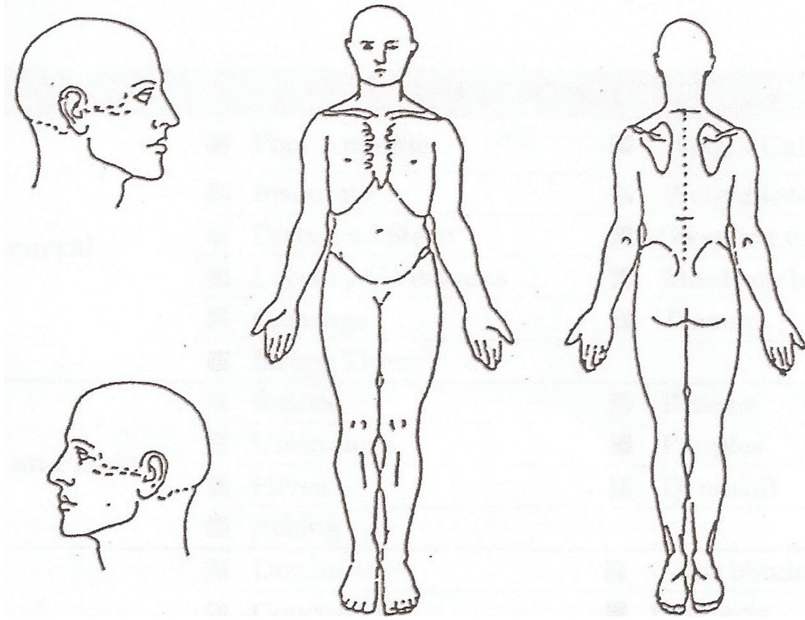
____

____

ALLERGIES: ____

____

PLEASE MARK PAINFUL OR DISTRESSED AREAS ON THE CHARTS BELOW



Symbol	Reaction
PAIN	
X	little
XX	moderate
XXX	strong
SWELLING	
^	slight
^^	moderate
^^^	severe
PULSING	
O	slight
OO	moderate
OOO	strong
WEAKNESS/TEMP.	
~	weak
+	hot
SKIN PROBLEMS	
*	skin issue

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild exercise (e.g. climb stairs, walk 3 blocks, golf)
- ☐ Occasional vigorous exercise (workout/recreation less than 4x/week for 30 min.)
- ☐ Regular vigorous exercise (workout/recreation 4x/week for 30 min.)

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Number of meals you eat in an average day:

Describe daily diet:

Caffeine

Indicate # of cups/cans per day ☐ Coffee _____ ☐ Tea _____ ☐ Cola _____

Tobacco

☐ Tobacco _______ packs per day Type? ___________ # of years _________

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If so, how many drinks per week?

Mental Health

Is stress a major problem for you? ☐ Yes ☐ No

Do you feel depressed? ☐ Yes ☐ No

Do you panic when stressed? ☐ Yes ☐ No

Do you have problems with eating or your appetite? ☐ Yes ☐ No

Do you cry frequently? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever seriously thought about hurting yourself? ☐ Yes ☐ No

Do you have trouble sleeping? ☐ Yes ☐ No

Have you ever been to a counselor? ☐ Yes ☐ No

Current Physical Symptoms

Category			
General	☐ Poor appetite	☐ Weight gain	☐ Night sweats
	☐ Insomnia	☐ Weight loss	☐ Fever
	☐ Disturbed sleep	☐ Sweating easily	☐ Chills
	☐ Localized weakness	☐ Bleeding/bruising	☐ Sudden energy drop
	☐ Cravings	☐ Tremors	☐ Poor Balance
	☐ Strong thirst		
Skin & Hair	☐ Rashes	☐ Eczema	☐ Recent moles
	☐ Ulcerations	☐ Pimples	☐ Changes in hair texture
	☐ Hives	☐ Dandruff	☐ Hair loss
	☐ Itching		
Head, Eyes, Ears, Nose, Throat	☐ Dizziness	☐ Color blindness	☐ Recurrent sore throats
	☐ Concussions	☐ Cataracts	☐ Nose bleeds
	☐ Migraines	☐ Blurry vision	☐ Grinding teeth
	☐ Glasses	☐ Earaches	☐ Sores on lips or tongue
	☐ Spots in front of eyes	☐ Ringing in the ears	☐ Facial pain
	☐ Eye pain	☐ Poor hearing	☐ Teeth problems
	☐ Poor vision	☐ Eye strain	☐ Headaches
	☐ Night blindness	☐ Sinus problems	☐ Jaw clicks
	☐ Photophobia	☐ TMJ	☐ Gum/teeth problems
Cardio-vascular	☐ Dizziness	☐ High blood pressure	☐ Swelling of feet
	☐ Low blood pressure	☐ Fainting	☐ Blood clots
	☐ Chest pain	☐ Cold hands or feet	☐ Difficulty in breathing
	☐ Irregular heartbeat	☐ Swelling of hands	☐ Phlebitis
	☐ Tightening in chest	☐ Palpitations	☐ Stroke
Respiratory	☐ Cough	☐ Bronchitis	☐ Frequent colds or flu
	☐ Asthma	☐ Shortness of breath	☐ Excessive phlegm
Gastro-intestinal	☐ Nausea	☐ Belching	☐ Rectal pain
	☐ Vomiting	☐ Black stools	☐ Hemorrhoids
	☐ Diarrhea	☐ Blood in stools	☐ Abdominal pain/cramps
	☐ Constipation	☐ Indigestion	☐ Chronic laxative use
	☐ Gas/bloating	☐ Bad breath	☐ Chron’s
	☐ Parasites	☐ Diverticulitis	☐ Colitis

Current Physical Symptoms (cont.)

Category			
Genito-urinary	☐ Pain on urination	☐ Incontinence	☐ Sores on genitals
	☐ Low to no sex drive	☐ Decrease in flow	☐ Impotence/frigidity
	☐ Blood in urine	☐ Kidney stones	
Musculo-skeletal	☐ Neck pain	☐ Back pain	☐ Hand/wrist pain
	☐ Muscle pain	☐ Muscle weakness	☐ Shoulder pain
	☐ Knee pain	☐ Foot/ankle pain	☐ Hip pain
	☐ Sciatica	☐ Tinnitus	☐ Arthritis
	☐ Migraines	☐ Varicose veins	
Neuro-psychological	☐ Seizures	☐ Poor memory	☐ Anxiety
	☐ Dizziness	☐ Depression	☐ Bad temper
	☐ Loss of balance	☐ Concussion	☐ Frequent mood swings
Other Illness	☐ HIV positive	☐ Rheumatic fever	☐ Eating disorder
	☐ AIDS	☐ Hypoglycemia	☐ Jaundice
	☐ Epstein-Barr	☐ Diabetes	☐ Hepatitis
	☐ Mononucleosis	☐ Underweight	☐ Overweight

Please list drugs, herbs and supplements you currently take:

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____

____

____

____

____

____

____

____

____

For Women Only

Age at onset of menstruation: __________ Date of last period: ________________

Period occurs every __________ days

Number of pregnancies __________ Number of live births ___________

Heavy periods, irregularity, spotting, pain or discharge?	☐ Yes	☐ No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder or kidney infections within the last year?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability or other symptoms at or around the time of your period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps or nipple discharge?	☐ Yes	☐ No

For Men Only

Do you usually get up to urinate during the night?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder or prostate infections within the last year?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No

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Patient's Consent for the Purposes of Treatment, Payment and Healthcare Operations

(Please sign and return)

I, ______________________________, give consent to Island Acupuncture to use and disclose my Individual Identifiable Health Information or Protected Health Information for these specific purposes:

1. to provide treatment to me,
2. to process payment for this service, and
3. for general administrative operations.

Protected Health Information is any information that includes:

1. Demographic information
2. My past or present health condition
3. My past or present financial information and agreement of future payments for healthcare services
4. Healthcare operations include quality assessment activities, credentialing, business management and other general operations, procedures or activities

I, ______________________________, refuse to give consent to this HIPPA form.

Date: ________________

I understand I have the right to request or put restrictions on the use and disclosure of my Protected Health Information for the purposes of treatment or payment of healthcare services by Island Acupuncture, but the clinic is not required to agree to these restrictions. However, if Island Acupuncture agrees to a restriction that I request, the restriction is binding.

I understand I have the right to read and discuss the *Notice of Privacy Policies and Procedures* from this acupuncture practice before I sign this consent regarding the use and disclosures of my Protected Health Information.

I have the right to revoke this consent, in writing, at any time except to the extent that the acupuncturist or the practice has already acted in accordance to this consent.

____

Signature of Patient or Personal Representative Date

____

Description of Personal Representative's Authority

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Acknowledgement of Receipt of Notice of Privacy Policies

The following acknowledges that Island Acupuncture has provided you with access to a *Statement of Privacy Policies*.

I, ______________________________, have read, reviewed, understood and agree to the *Statement of Privacy Policies* for healthcare services at Island Acupuncture.

____
Signature of Patient or Personal Representative Date

Acknowledgement of Receipt of Office Policies

The following acknowledges that Island Acupuncture has provided you with access to a *Statement of Office Policies*.

I, ______________________________, have read, reviewed, understood and agree to the *Statement of Office Policies* for healthcare services at Island Acupuncture.

I agree to provide at least 24 hours notice of cancellation and otherwise understand I will incur a charge of $40 for the missed appointment.

____
Signature of Patient or Personal Representative Date

Insurance Information & Checklist

Thank you for choosing Island Acupuncture for your healthcare needs. While acupuncture treatment and its benefits continue to become more integrated into the mainstream healthcare system, insurance companies in North Carolina are not yet required to cover its cost. Generally, our clinic does not file claims with personal health insurance plans, but we can provide you with copies of your invoices, which should contain all the information your insurance company needs. To help you speak with your insurance company in a way that might lead to coverage, we've provided the following checklist of questions that should be asked.

Checklist

1. Does my plan cover acupuncture?
2. Does my insurance cover these treatment codes:
   - 97810 – proc: acupuncture
   - 97811 – acupuncture additional
3. What is the annual acupuncture benefit (dollar amount or number of treatments)?
4. Does my plan require that an MD perform the acupuncture?
5. Does my plan cover acupuncture for the treatment of *(refer to your condition)*?
6. Does my plan require a referral from a Primary Care Physician (PCP)?
7. Does my plan require pre-authorization before treatment?
8. Does my plan require re-authorization after a specific number of treatments?
9. What is the phone number, FAX number or address that I should send reports, authorization requests and claims to?
10. Is there an applicable deductible amount that has yet to be met? What is that amount?

Name of representative spoken to: ______________________________

We also wish to support our patients whose insurance providers have not yet awarded coverage and do not recognize acupuncture as part of a benefits plan. As it is a political issue, we recommend that you write your insurance company and the State Insurance Commissioner to ask why North Carolina insurance companies are not required to cover such beneficial health services. This may encourage new discussions on acupuncture coverage. You might also wish to write your state representative and request support for insurance coverage of acupuncture services by Licensed Acupuncturists. Please find the address below.

It is our sincere wish that you gain as much coverage as possible. If you have any questions or concerns, please contact us at 252-449-8122 or islandacupunctureobx@gmail.com.

Jim Long, Commissioner of Insurance
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh NC 27699-1201
NC: 919-807-6750
Outside NC: 800-546-5664

House representatives vary by county.
Yours can be found at:
http://www.ncga.state.nc.us/House/House.html